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MARC J. VAN ROOSMALEN BA Hons DRS

THERAPIST INTERVENTION FACTORS THAT INFLUENCE  
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WITH MULTI-PROBLEM FAMILIES: A QUALITATIVE STUDY.

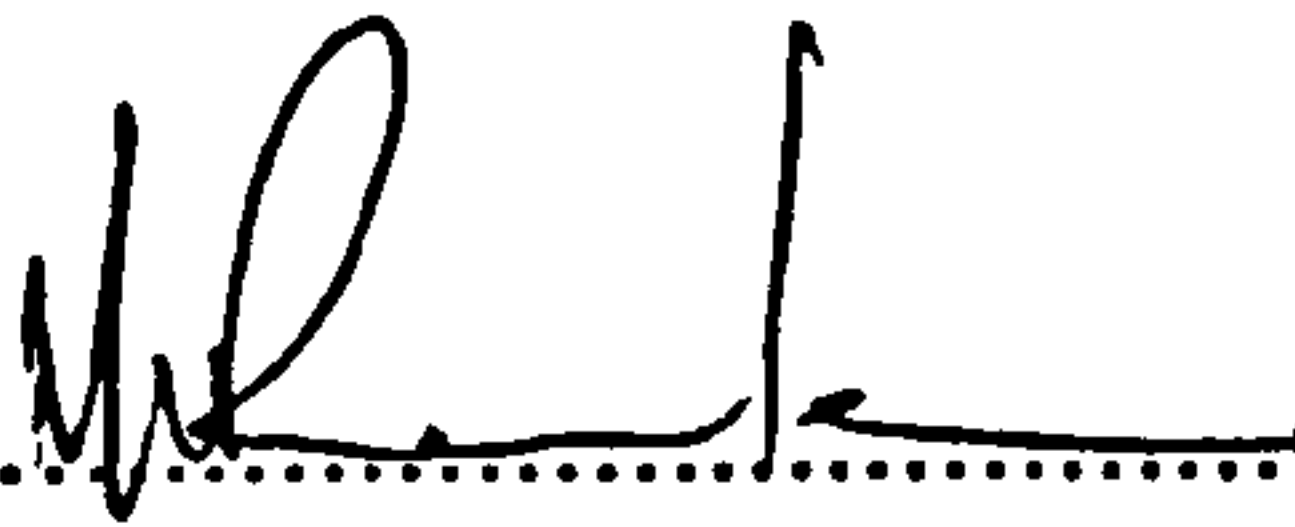
A thesis in partial fulfillment of the requirements of the Open University for the  
degree of Doctor of Clinical Psychology

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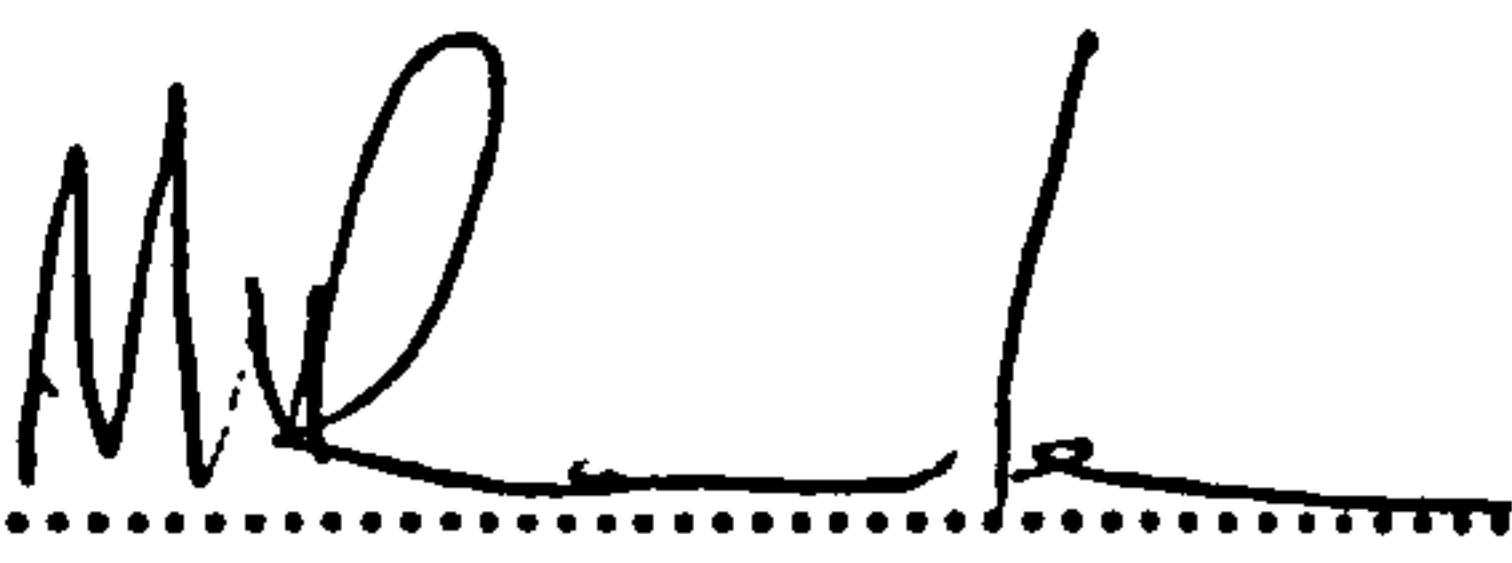
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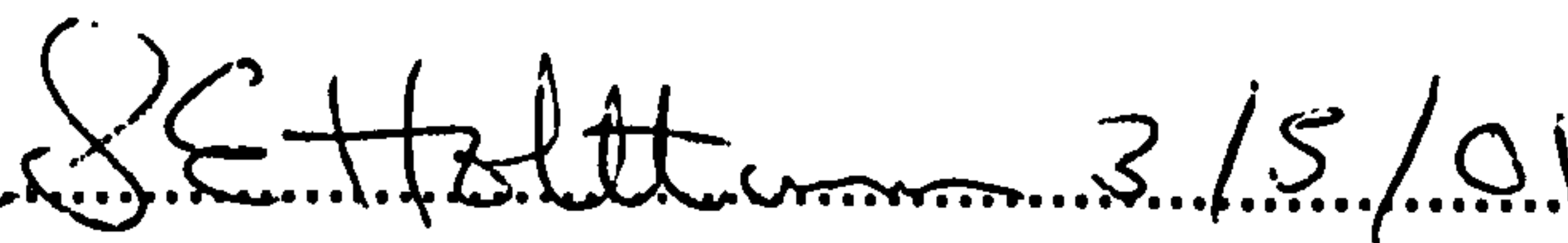
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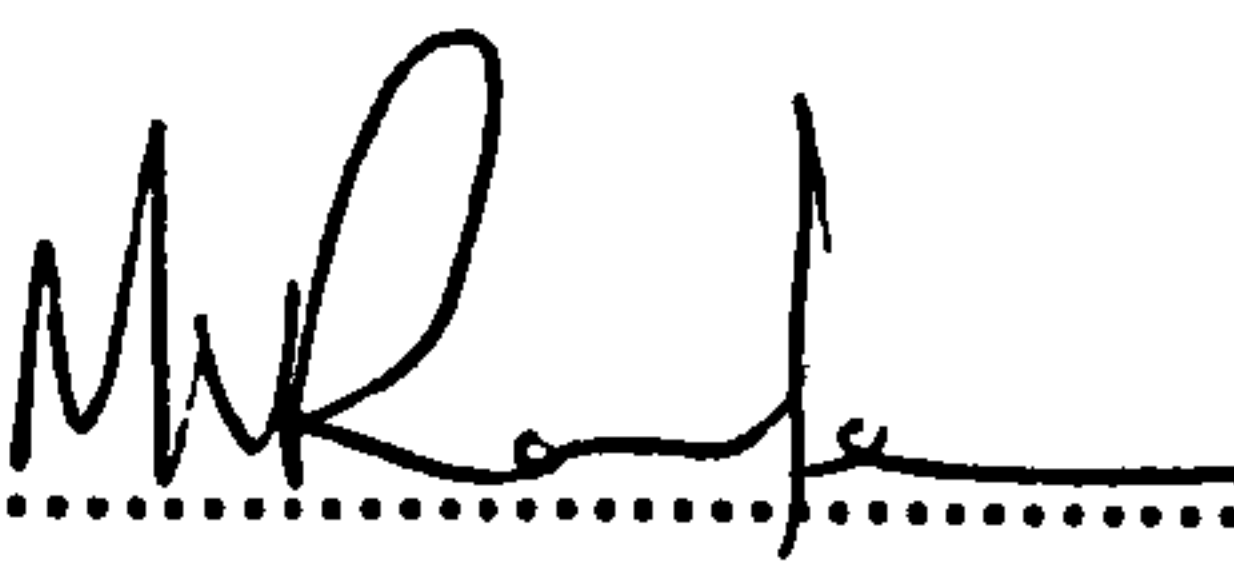
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## **ACKNOWLEDGEMENTS**

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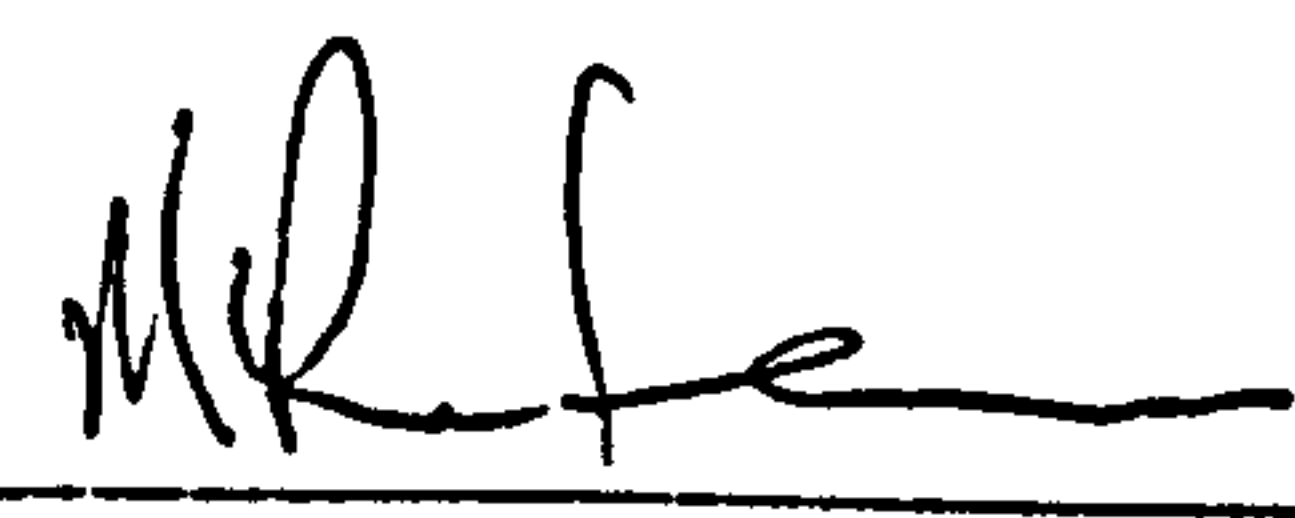
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## **ABSTRACT**

**Background and Aims.** The study investigates the therapist factors that influence the therapeutic alliance in family therapy with multi-problem families, from the perspectives of the child and family and structured commentary of the therapist. Due to the lack of research done with this client group and the adapted use of qualitative approaches applied, the methodology is also subject to scrutiny.

**Design and Participants.** A qualitative small-case design is used, to enable the collation of rich and detailed data of the meanings and experiences of the participants to emerge. Four family therapy cases at a child clinic are followed, using therapeutic alliance events as the units of investigation.

**Measures.** Interpersonal Process Recall, an interview method developed by Elliott (1984), gains the views of the participants, with Interpretative Phenomenological Analysis as the method of transcript analysis. The dual role of researcher and therapist is studied reflexively on various levels. An adapted Family Therapy Alliance Scale is also administered.

**Results.** A number of prominent themes emerged, namely, child therapy stance and technique, the children's communication style and a shift from an individual to systemic meaning of the difficulties. Others were being heard and listened to versus the experience of not being heard, working alongside the family, benefits and motivation in therapy and the experience of safety.

**Implications.** The study gives a useful account of the participants' views of which therapist intervention factors influenced the alliance and links with current research and theory. Prominent implications were the full participation of children, shifts in the meanings families ascribe to their difficulties and ways for therapists to collaborate with them. Evidence of the viability and limitations of the method used is provided.

Directions of further research are suggested.

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## **INTRODUCTION**

### **Personal Statement by the Author**

The child mental health centre where I work specialises in providing a service to families who require Tier Three (specialised) intervention (NHS Advisory Service, 1995), with the addition of Social Services involvement, due to the complex nature of their social and psychological needs. In my experience of working as a family therapist with these families, developing a workable relationship became a priority for me.

My own experience in clinical practice seemed to resonate with a growing interest in the family therapeutic field to “rediscover” and study the therapeutic relationship, which appears to have been a neglected aspect of family therapy in recent years (Anderson, Goolishian & Winderman, 1987; Anderson, 1992; Hoffman, 1993, 1998). Aligning with the child and their family became a task in itself for me. This meant, amongst others, making the views and issues of the family central from the initial stages of therapy. I was using various child therapy techniques to help the children express themselves in family therapy. These factors seemed to contribute to a positive therapeutic relationship, as the families’ attendance rates were good and they seemed engaged with and motivated to participate in the therapy.

I struggled to find literature that deals with working with multi-problem families. An exception to this was a paper by Cunningham and Henggeler (1999), who have been working with multi-problem families for several years, developed a family-based treatment model of therapy they called “Multisystemic Therapy”. They ascribed the higher rates of treatment completion to their commitment to collaboration and partnership with families. Thus collaboration seemed to be the key. The question



was how to achieve it, and whether my own experience could be set into a wider theoretical and practical context.

I have found very little research on how the family therapist can influence the therapeutic alliance. Kuehl, Newfield and Joanning (1990) and Stern (1999) established that although research had been done to understand the family therapy experience from the therapist or researcher's perspective, very little had been done to understand the client's perspective. The difficult relationship could be one of the very reasons why so little research has been done, but also possibly the motivation to do it.

I wanted to study how I as family therapist was having a positive influence on the therapeutic alliance with multi-problem families. In other words, what was I doing that helped develop a working alliance?

### **Intervening with Multi-Problem Families**

Working with multi-problem families produces many challenges. Among them are the difficulties the three statutory agencies (Health, Social Services and Education) and other agencies experience in coordinating their approaches to best serve the interests of the child. This is a task being addressed from the level of individual professionals to national policy level (Department of Health, 1999, 2000a, 2000b). A challenge at the level of child healthcare professionals is the issue of developing a workable relationship with the families.

Research literature on interventions with children who have complex social, psychological and possibly educational needs has indicated difficulties in forming a constructive working relationship with the parents, as a basis for resolving the presenting problems. Szapocnick, Kurtiness, Santisteban and Rio (1990) found the families of children with conduct disorders resistant to intervention. A history of non-

attendance and poor relationships between the family and the professionals is well documented in clinical practice, resulting in frustration and a sense of helplessness in all parties. In family therapy with child protection cases, Campbell (1997) and his research team found that the families experienced an overwhelming fear that their children would be taken from them. It was felt that the families consequently made it difficult to create a good therapeutic relationship with professionals. Other services either ignored or devalued views of this client group as biased or inconsistent. Campbell concluded that professional agencies should become more aware of the clients' views and issues.

### **Family Therapy and the Therapeutic Relationship**

To understand how the therapeutic relationship is construed in family therapy, it is easier to do so by understanding the development of the family therapy field itself. Dallos and Urry (1999) and Dallos and Draper (2000) explained the development by using the term "cybernetics". Cybernetics was a concept that came from the input-output model in engineering. They propose a three-phase development, namely, from first-order cybernetics, to second-order cybernetics (constructivism) and thirdly, the incorporation of social constructionist thinking.

In first order cybernetics, families were seen as a cybernetic system which could be controlled and thus changed from the outside. Therapy was characterised by the therapist taking on the position of the expert and the behaviour (of the child and the family) was the problem that needed modifying. Early systemic theorists such as Haley (1976) and Minuchin (1974,1991) did identify the therapeutic relationship as an essential determinant for the effectiveness of therapy. Subsequently, however, emphasis on techniques and the separateness of the various developing schools of



family therapy ensued, with the consequence that no coherent approach to alliance emerged.

The second phase, second order cybernetics, was influenced by postmodernism and led to a shift in family therapy that introduced a constructivist view of the therapeutic milieu. The constructivist position challenged the assumption that the therapist could take an objective observer position outside the family. The therapist became part of the family system. This phase saw the development of what became known as Milan Systemic therapy. The position of expert was more tempered by needing to understand the family system and be more cautious and question the therapist's effect on the system. Emphasis moved from viewing the behaviour as the problem in itself to the meaning behind it (Hoffman, 1993, 1998).

In their paper Dallos and Urry (1999) propose the integration of social constructionist ideas into systemic theory as a third phase in family therapy. The ability to gain an objective view of the world was questioned, with a shift away from objectively treatable structures in families (Anderson, 1992; Anderson, 1999; Anderson, Goolishian & Windermant, 1987; Gergen, 1985; Dallos & Urry, 1999), a move started by the Milan Systemic model in second order cybernetics.

According to social constructionist thinking, reality only exists within the meanings people give to it and exists in the social realm where language, action and meaning intersect (Hoffman, 1993). Meaning is not situated, for instance, in the problem that is presented by the family but in the interaction between the entire system that has a conversation about it. Anderson (1987) uses the term "problem determined system" to indicate that the system as such can involve anyone within the wider social structure, including the therapist and other organisations. This

acknowledges the therapist's (and the professional service's) part in construing the problem as such.

Developments in the Milan systemic model in the late eighties (Campbell, Draper & Huffington, 1989) have thus put the therapeutic relationship increasingly (back) under the spotlight. Recent and current research has recognised that emphasis on the techniques of family therapy has resulted in the neglect of the relationship between the therapist and the family.

Although nurturing this relationship would seem good clinical psychology practice, the challenge of collaborating particularly with multi-problem families, is very difficult. The therapist is part of a system that has and is making value judgements of the families and their capacity to parent their children (for example, by regarding them as families with multiple problems).

### **The Therapeutic Relationship and Therapeutic Alliance**

The therapeutic relationship has most commonly been described in both individual therapy and family therapy literature and research as the therapeutic alliance. Pinsof and Catherall (1986), who have studied the concept of alliance in family therapy, defined the therapeutic alliance as:

“that aspect of the relationship between the therapist system (*the family therapist and possibly, family therapy team behind the screen*) and the patient system (*the participating family in therapy*)<sup>1</sup> that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (p139).

They proposed the relationship to be the “vessel, or ...context in which therapy occurs” (p138).

---

<sup>1</sup> The words and explanations in italics were added by the present author.



The working alliance has been operationalised along similar lines by various authors who have studied the construct extensively since that time (Marmar, Horowitz & Weiss, 1986; Quinn, Dotson & Jordan, 1997; Pinsof, 1986; Pinsof, 1994; Martin & Allison, 1993; Horvath, 1994b; Barnard & Kuehl, 1995). A common origin has been the formulation of Bordin (1979, 1994) who, on studying the individual therapeutic process, defined the alliance as the active relational element in all change-inducing relationships, containing three aspects, Task, Goal and Bond. *Task* refers to the extent to which client and therapist agree and collaborate on the tasks of therapy. *Goal* addresses the extent to which the goals are mutually endorsed and valued by both parties and are the ends to which the tasks should lead. *Bond* is the complex network of positive personal attachments between therapist and client, including mutual trust, acceptance, and confidence. Agnew-Davies, Stiles, Hardy, Barkham and Shapiro (1998) found confidence (in the therapist) to be a distinct dimension of the alliance construct, and tasks and goals to fall under the same factor, partnership, which also included working together.

As family therapy includes more than two people, however, it brings complexity to the concept of a working alliance. Pinsof and Catherall (1986) identified three levels of alliance in family therapy, namely, whole system alliance (therapist with family members as a group), subsystem alliance (therapist with various subsystems, for example, the parents) and individual alliance (therapist with each individual family member). A fourth level could be the alliances between family members and its various subsystems. The therapist needs to form and preserve alliances with every member of the family, the subsystems, the family as a whole and be aware of splits within the family as well. Luborsky's (1994) description of the

‘therapeutic journey’ emphasises the process-like nature of the working alliance, whose achievement is provisional and to be protected continually.

On the basis of the extensive literature, the therapeutic alliance (though most studies refer to individual therapies) can be described as the active element in the therapeutic relationship and a continual process in therapy.

### **Difficulties in the Therapeutic Alliance**

The preservation of the alliance can be construed as a task the therapist needs to attend to throughout the therapeutic process. Bordin (1994) and Safran, Muran and Samstag (1994) respectively used the terms ‘strains’ or ‘ruptures’ to describe temporary breaks in the alliance (in individual therapy) which can occur throughout the therapy process and illustrate its dynamic nature.

Rait (1998) suggests that ruptures or strains in the alliance can be a learning opportunity for the clinician and family alike. He does not locate the source of difficulty in the family, but looks at the interaction between the therapist and family that could be leading to the impasse. This seems to make more sense than labeling the family as resistant to treatment. Misalliances can be of varying intensity and duration, ranging from momentary miscommunication to major obstacles to establishing or maintaining the therapeutic alliance and can result in therapy failure. Markers of alliance ruptures can include disagreement about goals or tasks of therapy, noncompliance, and nonresponsiveness to intervention. The author was not able to find studies investigating the nature of breaks and factors that could be contributing to them in family therapy. However, some studies have looked at the nature of alliance and the term ‘collaboration’.



## **Alliance and Collaboration**

Quinn, Dotson and Jordan (1997) equated the term “alliance” with “collaboration” in their paper, seeing both terms as defining a process of joining between therapist and client in determining the direction and nature of the therapy. Collaboration with families can take on different forms, as Hampson and Beavers (1996) found in their comparative outcome study of different family styles. Therapists who formed partnerships and employed a minimal power differential with more competent families, fared well in therapy. However, in the most disturbed families, therapists who employed a higher power differential and lower levels of partnership, did better in terms of positive outcome of therapy.

It was not entirely clear in their article what Hampson and Beavers (1996) meant by a higher power differential, and this concept could benefit from closer examination (see Discussion, p80). Cunningham and Henggeler (1999) found co-operation and close collaboration with the family to be essential to treatment success. The present author’s clinical experience seemed to lend support to their assertions. In addition, families with multiple problems seemed to collaborate better with a therapy style that was focussed on specific problems. In this context, greater structure may contribute to the therapeutic alliance with these families, and structuring might be seen in some light as employing higher power differential.

## **Alliance with the Referred Child**

Very little seems to have been researched or written on the alliance with children in family therapy and on methods or techniques to encourage their full participation.

Dare and Lindsey (1979) and Wilson (1998), the latter whose work included that with families in child protection, have written on the participation of children in family

therapy. They combined techniques of child psychotherapy with those of family therapy, using play techniques, drawing and taking into consideration the level of understanding a child has in his manner of questioning. Winnicott (1964, 1971) described play as the way a child masters ideas and impulses and their natural form of communication.

The findings of Dare and Lindsey (1979) and Wilson (1998) are consistent with what the author has found in his clinical experience. Children of multi-problem families, who usually have significant needs, can often neither express nor comprehend their difficulties and needs. It therefore seems likely that availability of play material and the therapist's willingness to talk with children using their preferred language would maximise the child's opportunity for personal expression. This also enables the therapist to convey understanding, which is thought to aid development of a working alliance with a child (Larner, 1996).

### **Alliance and Outcome**

The strong correlation between alliance and positive outcome has become well established in individual therapy (Luborsky, 1994; Hubble, Duncan & Miller, 1999). Research carried out by Quinn, Dotson and Jordan (1997) in family therapy demonstrated an association between alliance and therapeutic outcome.

In their review of family therapy process research, Friedlander, Wildman, Heatherington and Skowron (1994) found the family's level of willingness to engage in therapy and the sense of collaboration with the therapist to be predictive of session effectiveness and therapeutic outcome. However, they said that not much was known about the family's perspective on the factors contributing to the alliance and collaboration. The present study could possibly elucidate the family's views on this.



## **The Consumer's View of Therapist Factors**

As has already been stated, few studies were located that review the family's view of family therapy, particularly with multi-problem families. Treacher (1995) completed an extensive review of consumer studies of family therapy, which were done with families attending child guidance or marriage counseling clinics. No studies in his review targeted multi-problem families. In one of the studies, Crane, Griffin and Hill (1986) emphasised the ability of the therapist to present therapy as consistent and congruent with 'consumer expectations' and that the therapist must select the treatment approach to match the family's expectations. In their study of hindering and helpful events in both explorative and prescriptive individual psychotherapies, Llewelyn, Elliott, Shapiro, Hardy and Firth-Cozens (1988) found awareness of the problem identified by the client and its solution in therapy to be the most common helpful events reported by clients. Clients felt hindered by what they perceived as misdirection (that is, therapy progressing in a direction perceived as irrelevant).

In Campbell's (1997) review, a consistent finding was that therapy was not answering their needs and expectations. Rutherford (who worked in a research team with Campbell) studied the responses of "working-class families" to family therapy. Most families were dissatisfied with therapy, as they experienced the therapist as not understanding their problems. It seemed to emphasise how necessary it is to find out the clients' experiences and expectations of family therapy.

Bennun (1989) studied the ratings completed by thirty-five families, who described their perceptions of their therapists. He noted that the more divergent mother and father's views on therapy, the less likely therapy would be successful.

Also, if fathers rated the therapist as having a competent and directive style early in the therapeutic process, it had a strong association with positive therapeutic outcome.

In their exploration of a client-based description of family therapy (with white, middle class participants), Kuehl, Newfield and Joanning (1990) reaffirmed the importance of therapist characteristics as personable, caring and competent and able to generate relevant suggestions. However, clients experienced therapists to have areas of selective deafness, suggesting therapists can be resistant as well. Kuehl et.al. postulated that the therapist becomes resistant when he or she proposes a problem or solution a family will not accept.

In developing and researching a systemic therapy for multi-problem families, Cunningham and Henggeler (1999) found several non-specific or universal strategies to be central to developing an alliance, according to the families. Therapist empathy was rated as one of the most helpful experiences, another was the family receiving direct and immediate benefit during initial sessions. Family members also needed to believe in the competence of their therapist and the viability of the interventions being recommended.

Safran, Muran and Samstag (1994) saw growing evidence of the therapeutic alliance as a key component in therapy, with the equal efficacy of different forms of therapy. If therapy was effective (whatever the technique) then alliance would also be found to be good. It seems difficult to prove the direction of causality, whether good alliance led to effective therapy or good therapy technique led to good alliance. It is possible that in Safran, et al.'s study, the therapists all had some element of alliance-building as party of their therapy, irrespective of model. Perhaps it is this element, which may be unspoken or not sufficiently elucidated, that needs further study.



## **The Study of Therapy Process**

In examining the question of the nature of a therapist's interventions that could be influencing the positive working relationship with the family, a key issue to be tackled is deciding on an *appropriate method of analysis*. The therapeutic alliance is a conceptualisation of relationship and interaction processes between the parties. It assumes internal states, processes and expectations in the participating individuals and as such, cannot be observed directly although behaviours can be. The large number of people involved in family therapy makes the alliance with a family a complex concept. Therapist factors that influence the alliance are also experienced by the (multiple) participants.

On this basis, a study that attempts to understand how therapist factors influence the alliance could usefully investigate the experiences the participants had of it (i.e. the relationship with the therapist) and what they think the therapist does to make it a positive one. The experience of the children (who are the referred clients) should be an aspect of such a study, since their views are often not considered in the few studies reported in the literature.

Friedlander, Wildman, Heatherington and Skowron (1994) conducted a review of all published process studies on family therapy, which included studies relating to the therapeutic relationship. Most research was concerned with observable behaviour rather than the experiences of the participants in therapy. This preference for 'objective' methods over phenomenological ones reflected the importance given to this type of scientific inquiry. A consequence was that not much was known about effective therapy from the family's perspective, as observer ratings only provided one viewpoint, that of the researcher or therapist. Friedlander, et al. identified the need to

study how family members themselves construe various therapeutic events as influencing the process of change.

Pinsof and Wynne (2000) presented a new strand of research in family therapy following their extensive review of family therapy research and its relation to clinical practice. They advocate a new kind of “progress” research that integrates process and outcome perspectives. It should be an attempt at clinically informative and practical research that is orientated towards the clinician, to inform when interventions applied in clinical practice are not working and to suggest avenues of more productive intervention.

### **Accessing Therapeutic Experience**

Appropriate strategies need to be considered to access data from the participants in therapy. Pinsof (1989) found that observational methods were most appropriate to measure behaviour or action (process), while self-reports measured experience (content). This was confirmed in Friedlander, Wildman, Heatherington and Skowron (1994) and Pinsof and Wynne’s (2000) extensive reviews of family therapy research and commentary. According to both reviews, to develop methods identifying therapist interventions that can be linked to client change, family therapy research requires new client self-report measures, rather than observation measures.

Newfield, Kuehl, Joanning and Quinn (1990) argue that ethnographic interviewing<sup>2</sup> is an important methodological tool that can challenge the therapist’s tendency to view therapy research as a therapist-dominated process. A problem with

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<sup>2</sup> In ethnographic interviewing the interviewer adopts the position of learner who needs teaching or informing about the topic being explored, with the interviews conducted in an open-ended way. The informants are prompted to lead the researcher into an understanding of how they perceive the situation.



this approach is that the complexity and sheer volume of the psychotherapeutic interaction brought the resultant danger of being swamped by data. Drawing on Rice and Greenberg (1984), Elliott (1984, 1986) developed a discovery-orientated approach to events in therapy that elicited the experiences and perceptions of clients and therapists. He described the potential of Interpersonal Process Recall (IPR) in (individual) psychotherapy research as combining a phenomenological with a process rating approach. By eliciting recall of significant moments in therapy from clients, it combines event-based specificity of the therapeutic process with the clinical relevance and richness of client self-report data. These are usually missing from even the best transcripts or recordings of therapy sessions, because the participants do not stop to comment on what is happening.

IPR has been successfully applied to individual therapy (Elliott, 1984; Hill, Helms, Tichenor, Spiegel, O'Grady & Perry, 1988). Friedlander, Wildman, Heatherington and Skowron (1994) and Pinsof and Wynne (2000) suggest its potential usefulness to study family members' perspectives on the process of family therapy. With the emphasis on process and experience of the participants in family therapy, examining microchange processes within sessions rather than whole sessions is regarded as a good strategy (Pinsof, 1989). Campbell (1997) had used a similar method, and preliminary results seemed to indicate its usefulness.

A question that arises with this approach is whether the client is able to give feedback on their experience of therapy, in other words, to be 'reflexive'. Rennie (1992), who defined reflexivity as a turning back on the self, regarded it as a necessary requirement for any therapeutic process. He identified it as a core quality experienced by the client in (individual) therapy and thus acknowledged this ability in the client.

## **Analysing Consumer Experience**

The information gained from the participants in family therapy needs to be analysed in a way that validates their experiences. This entails analysis at the level of self-reported cognitions, if the basis is that their views are useful. A second premise is recognising the interactional nature of the phenomena studied. Due to the explorative nature of the present study, an inductive design would enable a “bottom up” approach and the emergence of new data and patterns. Smith (1996, 1999) has developed an inductive research method called Interpretative Phenomenological Analysis (IPA). IPA combines the analysis of social cognitions with the recognition that these occur in and as a result of, social interactions. He combined the theoretical ideas of phenomenological psychology and “symbolic interactionism”<sup>3</sup>. IPA recognises language in shaping the responses of participants and the interpretative role the researcher takes in attempting to get close to the participant’s experiences. In discourse analysis, on the other hand, discourse and context are the focus of analysis, but cognitions are not recognised as valid units of study (Potter and Wetherell, 1994). IPA (Smith), however, concerns itself with what respondents think or believe about the subject, and that they can be valuable and valid informants.

Smith (personal communication) regards IPA as a form of grounded analysis. Gilgun (1992) explained the purpose of grounded theory as an inductive approach to research that develops theory, a ‘bottom-up’ approach. The author understands IPA as not primarily aiming to theorise, but as a starting place from which to explore a

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<sup>3</sup> Symbolic interactionism represents a rejection of the positivist paradigm and was influenced by phenomenology and by the philosophy of pragmatism. Central tenets are that the meanings individuals ascribe to events should be of main concern and that these meanings can only be obtained through a process of interpretation. Meanings occur in and as a result of, social interactions (Smith, 1996).



topic that has received minimal research attention. A possible next step could be the generation of middle-range theorising, which grounded theory attempts. IPA could also appeal to research which has clinical utility, as it could potentially generate a greater understanding by exploring the experiences and meanings of participants of therapy. Grounded analysis is also an extremely time consuming method of analysis, whereas IPA is less so, lending itself more towards research in the clinical setting.

IPA is conducive to examining small samples in detail, exploring in depth how participants respond to a particular topic.

### **Case Study Designs**

Contextual conditions are pertinent to studies of family therapy process, as the alliance and the therapist factors influencing the alliance take place in a particular (therapeutic) context. The rationale for a case design, as outlined by Yin (1994), lies in investigating contemporary data within their natural context, where the boundaries between the phenomena and the context are not clear and the former has many variables of interest. The experiences of participants can inject richness and subtleties into understanding the topic of research. Good and Watts (1996) emphasised “how the significance of an action can be understood by reference to its setting, the personal and cultural practices within which it arises (p269)”.

A study of therapist interventions along the course of therapy allows its dynamic and flowing nature to be taken into account. The goal of case studies is not to provide a generalisable account, but is part of a process of theory development (Hayes, 1997).

## **Participant Observation**

Issues arise for clinicians who want to conduct research, particularly when they are in the dual role of researcher and therapist. Junker's (in Vetere, 1987) discussion on observational studies is helpful in describing the various roles of a participant observer. A continuum ranges from the complete participant (totally involved in the group) to the complete observer (totally detached, no contact with group members). A participant observer does not hide the fact that he/she is observing while also a participant and thus part of the "in-group" (i.e. part of the family therapy group process). The participant observer has a group participant role but the freedom to make observations outside of the "in-group". He/she thus lies near the middle of the observation continuum, but more toward the complete participant than complete outsider. Data are being accessed due to the role taken as participant which otherwise might be more difficult to access. The dual roles, however, need to be clear and careful attention paid to methodological issues, such as the effect the researcher has, as participant (therapist), on the process. Triangulating different sets of data increases the probability of rooting out idiosyncratic interpretations of events, and builds a richer account thereof, according to a review of participant observation methods by Good and Watts (1996). The review revealed the necessity of clarifying the basis on which reports are made.

## **Measuring the Therapeutic Alliance**

To corroborate evidence given in free response in interviews by all the participants in the research, gaining an idea of the quality of the therapeutic alliance via a standardised measure could be useful. Pinsof and Catherall (1986) have developed the only family therapy alliance scale to date. Their scale was based on Bordin's



(1979, 1984) operational definition of the therapeutic alliance and appears to have been successful in terms of measuring the alliance as a construct. It is described in more detail in the Method Section.

### **A Preliminary Study**

A preliminary single-case study with one family was conducted before commencing on the present study. The present author used IPR (Elliott, 1984, 1986) with the family in a group setting. As far as the author could find, IPR had not been attempted before in a group format. Individual interviews with family members were not conducted, due to the amount of additional time this would entail for the family, possibly putting them off participating. The IPR interviews produced valuable and relevant information during the single-case study. Subject to one proviso (discussed next) it was concluded tentatively that IPR could be applied in this study context to further investigate its appropriateness as a group interview technique.

One important finding from the preliminary study was that the referred child found it difficult to participate in the IPR, saying very little. The IPR situation seemed intimidating and embarrassing. A one-to-one and semi-structured interview format was used with the child. This step was coherent with the view that children are valuable and valued sources of information. In this way it was hoped that meaningful information could be obtained from the referred child, and still without adding too much additional time burden to these families with multiple problems. This was important considering the existing level of difficulty in engaging the families.

## **A Rationale for the Present Study**

The present study intended to investigate therapist factors that influence the therapeutic alliance in family therapy with multi-problem families. Research with respect to this client group is minimal, particularly exploring family and children's perspectives of aspects of the alliance.

To enable an analysis of a concept that is arguably a largely subjective interpersonal phenomenon, i.e. the alliance, the experiences of the participants needed to be explored. The experience of the family could provide valuable information about their perception of how well they and the therapist were working together and what affected it. IPR was used to examine the participants' perceived working relationship with the therapist. Conducting a group interview method was, as in the preliminary study, a practical decision.

The question remained how specific alliance related "events" could be identified. In his study, Campbell (1997) himself chose the events to go through with the families. However, the present method entails the clients themselves picking out "events" in the therapy that were significant for them, emphasising the centrality of their perspectives to the study. This approach is more like Elliott's method used in individual therapy (1984, 1986). The referred child would be interviewed separately and individually.

The rationale for a case design was the pertinence of contextual conditions. The small number of families participating in the research seemed justified by the qualitative method of analysis. The emphasis was on attention to detail as opposed to numbers of participants, given that analytic rather than statistical generalisability was sought (Yin, 1994).



To corroborate the self-report evidence given by the participants concerning the nature of the relationship with the therapist, the quality of the therapeutic alliance throughout the therapy process was measured. Due to the amount of evidence already gained, a brief quantitative measure seemed most effective. An adaptation of an existing questionnaire was used (see Method).

The dual role of researcher and therapist (observer and participant) seemed to bear a need for reflexivity. Psychology has not made much use of a participant-observer methodology. On another level a self-reflexive reflection on the dual role itself would be necessary to be methodologically consistent.

It is imperative to take into account the client group and clinical setting within which the research will take place. Issues arise for clinicians who want to conduct research in the clinical setting, amongst which is how the families experience their participation in the accumulation of the data. This and other issues are dealt with in the section on ethics in the Method Section.

The method of analysis aimed to provide compelling evidence of the therapist's interventions that could influence the alliance. Triangulation of data would introduce some rigour in providing evidence collated from various sources.

## **Research Aims**

The study investigated the following:

1. What therapist intervention factors influence the therapeutic alliance, from the perspectives of all (the adult and child) family members participating and of the therapist?

2. Does the method of analysis proposed here for studying therapist's intervention factors in the development of the therapeutic alliance in family therapy have clinical utility?

The study explored, developed and refined an inductive and participative methodology to attempt to address both aims. The study was exploratory, on both a methodological and conceptual level.

## **METHOD**

### **Research Design**

A multiple-single case explorative study was conducted to investigate the two research aims. The first family therapy case was used as a pilot to test the method of data collection and analysis, after which the method was standardised to enable cross comparison of results between the four family therapy cases. The names of the families were changed to ensure anonymity.

### **Participants**

The participant families were obtained from the clinical setting of the researcher, a child mental health clinic. Before giving written consent the family received a written summary of the details of the research (Appendix 1). A participant number of four family therapy cases was aimed for, with a minimum of five therapy sessions necessary for each case in order to complete at least two interviews with each family. The children fell within the client group of children with complex needs, which included the requirement of a Tier Three intervention (NHS Advisory Service, 1995), with the addition of Social Services involvement. The family therapy team consisted of the present author as the family therapist, with a team of between one and three family therapists behind the screen.

### **Family Therapy Approach**

A list of points outlines the approach taken to therapy, which encompasses, amongst others, the criticisms made by social constructionist thinking of systemic practice:

- Initiating partnership in therapy by specific systemic strategies, such as gaining the views of all family members and recognising the value of each.



- Use of non-specific techniques such as genuine interest and empathy.
- Working from a position of where the family 'is' in relation to the presented problems and continuing to work at the pace of the family.
- Structuring of the sessions around the issues the family come with.
- Attempting to gain the full participation of the children in therapy, by using child-friendly techniques.

### **Measures and Materials (Qualitative)**

Data were gained from three sub-systems of participants (family, referred child and therapist) in the therapeutic process. This was in keeping with validity checks discussed for a participative methodology in the Introduction section, such as triangulation (see Triangulation below), having more than one observer of the collated data (see Independent Audit below) and the knowledge brought by the participant-researcher (see Introduction and Family Therapy Approach above). The researcher, as a direct participant (therapist), was a crucial link in gaining knowledge of the alliance events chosen as significant in the therapeutic process. However, due to the potential of being overly biased, the therapist's experiences of the events were regarded as structured commentary.

### ***Semi-Structured Interview with the Participant Family***

Interpersonal Process Recall (IPR) (Elliott, 1986; Alexander, 1996), developed for use in individual therapy, was used to elicit the family's experiences of alliance events and the therapist factors that influenced them. In order to ascertain from the participant family (at the end of the therapy session) in which specific part of the session they experienced the alliance as particularly strong, or conversely as weak,

the therapist/researcher asked the family: “was there any part of this session that you found you were working particularly well together with the therapist, or where you felt you weren’t?”. The question was framed in this way to try to encapsulate the therapeutic alliance as a construct, as defined by Pinsof and Catherall (1986) (see p5). If family members identified different events in the session, the researcher would encourage negotiating a common event they could agree on. This is a point that needed careful monitoring to consider the appropriateness of the method to a group and to note whose “events” were not chosen. Interviewing each family member individually was considered, but it would not have been practical because of the additional burden on families already partly alienated from services.

Immediately following the session, the alliance event the family identified was played back to them on video. A semi-structured interview was used with the whole family simultaneously (Appendix 2) to elicit their experiences. The seven open-ended questions were devised to investigate therapist factors which influenced the alliance events. The first two questions explored the family’s experience of the event, the third and fourth questions what the therapist did to contribute to the event. The fifth elicited the impact of the event on the alliance between family members, acknowledging the complexity of the alliance in family therapy. The six and seventh questions asked how the event impacted on their relationship with the therapist and their continued attendance of family therapy.

### *Child Therapeutic Alliance Interview (CTAI)*

The Child Therapeutic Alliance Interview (CTAI) (Appendix 3) was a semi-structured interview devised by the author and a colleague (see below). It was used as an adjunct to the interview with the family.



The individual interview format with a child seemed a more appropriate format to gain their views than relying on a family interview. The literature suggests that children find it hard to discuss their experiences in front of their parent(s), due to the effect they think it could have on the latter and position in the family regarding the identified problem (Mas, Alexander and Barton, 1985; Yule and Canterbury, 1994). This was supported in the preliminary study by the present author, where the referred child seemed to find participation in the family interview very difficult. Studies by Stith, Rosen, McCollum, Coleman and Herman (1996) and Strickland-Clark (1998) found the individual format with children to be a useful way to gain their views of family therapy. This was supported again in the preliminary study. However, the child was also given the opportunity to participate in the family interview.

The author and an experienced Consultant Child Psychotherapist developed the interview schedule. The FTAS (Pinsof and Catherall, 1986) and the Helpful Aspects of Therapy Questionnaire (Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988) were used as guidelines, although neither were designed specifically for children. The consultant used her considerable clinical and research experience to help develop the interview schedule, for instance, in the use of developmentally appropriate terminology with children, and the sequencing of questions.

The semi-structured interview consisted of fifteen open-ended questions. The first eight questions, the thirteenth, fourteenth and fifteenth investigated the alliance between the therapist and child and therapist factors influencing it, for example, "Do you think the therapist understands that (what child finds worrying)?" Questions nine to twelve investigated the alliance between the child and his/her parents and other family members. An example was "What does mother think is wrong /



worrying?”. All of the question prompts corresponded to aspects of the concept of therapeutic alliance.

The interview was held simultaneous to and separate from the family completing the Family Therapy Alliance Scale (FTAS) for three reasons. Firstly, to hold the interview after the family interview would be repetitive, tiring and demanding for the child, particularly following a family therapy session. Secondly, two consecutive interviews would be time-consuming for the family. The third was convenience, as the child did not complete the FTAS due to his/her young age. To give the referred child more time to engage with the setting and therapy, the interviews were only started following the third therapy session instead of the first.

The child interview was thus held following alternative sessions to the family interview. Due to the process and continuous nature of the therapeutic alliance as a construct (for example, Green and Herget, 1991; Luborsky, 1994) this decision was felt to be methodologically justifiable. This issue will be returned to in the Discussion Section.

#### *Structured Commentary by the Family Therapist*

A structured commentary of the alliance events was recorded by the family therapist/researcher (ie. participant-observer). The therapist recorded his own responses to the same semi-structured interview schedule as used with the family (Appendix 2). The commentary was recorded immediately following the family interview. The therapist thus hoped to elicit his perspective, as participant-observer, of the alliance events identified by the family.

### *Interpretative Phenomenological Analysis:*

The audiotaped interviews were transcribed. Interpretative Phenomenological Analysis (IPA)(Smith, 1995; Smith, Jarman & Osborn, 1999) was used to analyse the transcribed material, with a view to extracting themes that the family identified as important to the identified alliance event and the therapist factors they perceived to influence it. IPA was used to analyse the CTAI transcripts to identify the child's themes. The therapist commentaries were also analysed using IPA. The author's position as both observer and participant will be reviewed in the Discussion.

### *Research Diary*

The author made a further, less formal commentary on the process of the analysis of the interviews. The aim was to address the reflexive process, in narrative form, of all the IPA analyses conducted (Appendix 5).

### **Measures and Materials (Quantitative)**

#### *Family Therapy Alliance Scale:*

The Family Therapy Alliance Scale (FTAS), a standardised questionnaire, was used in adapted form to elicit the family's experiences of the nature of the working alliance. It was intended that all family members who were able to complete the questionnaire, did so, including the referred child and any siblings (if old enough to understand and complete)<sup>4</sup>. The questionnaire was based on the alliance scale developed by Pinsof and Catherall (1986)(49 items), who have developed the only family therapy alliance scale to date. Their scale was based on Bordin's (1979, 1984)

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<sup>4</sup> In the event, the referred child never completed it because he/she was too young.



operational definition of the therapeutic alliance and has been shown to have good test-retest reliability ( $r = .83, p < .005$ ).

The author shortened the scale from forty-nine to thirteen items as the length of the original was felt to be too long and not suitable for the client group due to the nature of its language (for an American population and middle class). It was intended that all levels of alliances between different participants as represented in two of the dimensions, Bond and Goal, were chosen to represent the alliance. The third dimension, Task, was to be left out in order to reduce the length of the scale. This decision was informed by the social constructionist metatheoretical position that places the setting of goals and the conversation about them to be of greater importance than the more concrete setting and completion of specific tasks. Eron and Lund (1993) suggested that the conversation was regarded as often being sufficient to achieving the goals, with the completion of tasks as less important. In the event, on re-examining the items of the scale following completion of the research, the author found that the items attributed to the dimension Bond, in fact represented the dimension Task. The scale thus represented largely the dimension Task (nine items) and not Bond. Omitting one dimension and reducing the items on the other two dimensions limited the FTAS technically and conceptually and placed its validity in question. It would be reflecting only two of the three dimensions of the original scale and of the therapeutic alliance as a construct. Furthermore, the changed wordings were not piloted. It might, however, be useful as corroborative evidence to triangulate the qualitative data, even considering the error just described, in terms of 'Task' issues.

The resulting questionnaire was an unvalidated one. A shortened version of the original scale was due to be published, but at the time of this project was not yet



available (Pinsof, personal communication). It was hoped that completion by all parties, including behind-screen observers, might mitigate some of the problems discussed above since a high level of agreement between observers and participants might be considered to imply a degree of reliability to the measure.

The scores on the scale ranged from one to seven (Likert scale), with the higher the score, the stronger the alliance indicated by the scorer. The Family Therapy Alliance Scale for Therapists (FTAS-T) and for Observers (FTAS-O) used the same format as the FTAS, with the questions adapted (by point of reference) for the therapist and therapist observers (observing family therapy team behind the screen) respectively (Appendix 4). The scale was completed individually by all family participants. Both scales were analysed graphically, presenting the strength of the alliance at different stages of therapy by the family members, therapist and therapist observers for ease of cross-comparison.

### **Methodological Criteria**

It has been argued that different means of evaluating the quality of qualitative research are needed relative to quantitative research, as the former approach has different epistemological priorities (Smith, 1996). Henwood and Pidgeon's (1992) and Smith's criteria were largely applied.

### ***Triangulation***

Converging multiple sources of evidence provided data that were rich, complex and meaningfully related to the problem domain. An example was that information regarding either the strength and nature of the therapeutic alliance or identifying therapist factors that influenced the alliance was obtained from all participants

involved in the family therapy cases (i.e. family members, therapist and therapist observers).

### *Reflexivity*

The reflexive character of the research ensured that the rationale behind methodological decisions was explained and made as transparent as possible, as was the role of the researcher in the research process. The researcher's thoughts while analysing the qualitative data were written up in a research diary (Appendix 5). This will be reviewed in the Discussion section. Theoretical assumptions as family therapist are presented in an earlier section (Family Therapy Approach), where the researcher's approach to family therapy is outlined.

### *Independent Audit*

Independent audit is a form of validity checking. An appropriately qualified professional checks whether a coherent chain of arguments runs from the raw data to the final write-up, to support the principal researcher's claims. Smith (1996) suggested a two-step process. The first entails setting the data in such a way that another person could follow the chain of evidence that led to the final report. The second and more advanced step is to actually conduct an independent audit, which entails independent verification of the analysis completed. This process attempts to validate the author's particular reading of the families' transcripts. Smith (personal communication) described the second step as one that few researchers incorporate in their studies and one that encourages the researcher to be explicit about the analysis that was conducted.

The author subjected two of the four families' analyses to this two-step process, with the two families being randomly chosen by two independent auditors. Each auditor was given the full original transcripts of all the family, child and therapist interviews of the family with initial codes and emerging themes. The subsequent tables of the IPA analyses (initial codes, emergent, super ordinate and master themes) of all the interviews were also issued. Each auditor needed to validate the entire systematic sequence of analysis for the IPA, from the raw data up to the master themes.

Following the audits, the author held a discussion with each auditor separately, taking into account their evaluations at each step of the analysis. This involved going through each interview and its IPA, with those themes confirmed and disconfirmed noted. The critical discussions led to a refinement and (at places) modifications of the analysis. With the modifications in mind, the author went through the interviews and IPA analyses of the remaining two families and made changes in the corresponding themes.

The auditors were a research tutor in clinical psychology and an experienced clinical psychologist and family therapist.

### *Internal Coherence*

The provision of definitions of concepts and classifications should allow the fit of data and research questions to be evaluated.

Assumptions were documented by sampling the decisions that were made, through the extraction of illustrations. An example was that the results of the IPA were illustrated with the help of tables, where the progress from the raw data to the main themes was shown.



The contextual features of the study were given in order to aid “transferability” or applicability of findings to other contexts (for example, the demographics of the families, description of alliance events, clinical information and ethical issues).

### *Researcher Bias*

Bias could be introduced into the research by the approach taken as family therapist (p22) and his corresponding interests. For example, the therapist identifies alligning with children in his approach, with the consequence that the author could be biased in data collation and retrieving this from the data. The open-ended nature of the interviews, family identification of alliance events and independent audit hopefully minimise this bias. The prominence of the family and child interviews in terms of weight of evidence in relation to the therapist commentary could also protect against unhelpful bias.

The therapist commentary could be overly biased, due to the knowledge the therapist/researcher had of the project and what was an expected and desired outcome. To guard against this bias, the material from each of the two interviews and structured therapist commentary has been analysed separately and the findings subjected to independent audit. The results from the analyses of the three sub-sections of participants are also presented separately in the Results Section. The above methodological criteria, along with clinical and research supervision, were part of the attempts to attend to these biases. The main way, however, would be to make the method of research, the analyses of data and the results as transparent and visible as possible to the reader, and along with the reflective diary, to enable appraisal of the findings with the fullest possible knowledge.

The effect the research interviews have on the therapeutic process needs to be monitored and taken into account (see Discussion section) when reviewing the methodology. It would be inconceivable that the interviews, although separate from the therapy sessions, would not have some effect on them, particularly with the author in the dual role of researcher and therapist.

## **Procedure**

If systemic work was indicated to be clinically appropriate as a result of an initial assessment by the local child mental health team, the family was invited for a family assessment appointment. After the family therapist (also the researcher) and family therapy team had agreed with the family that systemic work would be started, written consent from the family was obtained for participation in the research. The session-by-session research procedure was the following:

### *Session 1, 3, 5 and Further Alternate Sessions:*

The family members were asked to complete the FTAS individually at the end of the family therapy session. Simultaneously, the therapist interviewed the referred child, using the CTAI. The therapist completed the FTAS-T. The family therapy team (observers) completed the FTAS-O.

### *Session 2, 4 and Further Alternate Sessions:*

Interpersonal Process Recall (Elliot, 1986) was conducted with all the family members present immediately following the family therapy session. It took approximately twenty minutes.

The IPR interviews followed the second session and not the first. It seemed that the questionnaires would be an easier first step into the research for the family than an interview, which could be quite intimidating initially. The decision was a clinical one.

The IPA’s of all the transcriptions were conducted after the therapeutic sessions were completed. Table 1 below illustrates the methods of data collation, the participants involved and the type of data that were produced at each stage of this project.

**Table 1. Methods of data collation**

<b>Data Collection</b>	<b>Timing</b>	<b>Participants</b>	<b>Nature of Data Collected</b>
IPR	Session 2, 4, 6, etc.	All members of the family who attend the session, together	Therapist factors influencing an alliance event in a family therapy session (event identified by the family).
IPR	Session 2, 4, 6, etc.	Therapist	Therapist factors influencing an alliance event in a family therapy session (event identified by the family).
CTAI	Session 3, 5, etc.	Referred child	1. Quality of the therapeutic alliance at that point in the family therapy sessions. 2. Therapist factors influencing the alliance.
FTAS	Session 1, 3, 5, etc.	All members of the family who attend the session, individually	Quality of the therapeutic alliance at that point in the family therapy sessions
FTAS-T	Session 1, 3, 5, etc.	Therapist	Quality of the therapeutic alliance at that point in the family therapy sessions
FTAS-O	Session 1, 3, 5, etc.	Observing Family Therapy team	Quality of the therapeutic alliance at that point in the family therapy sessions

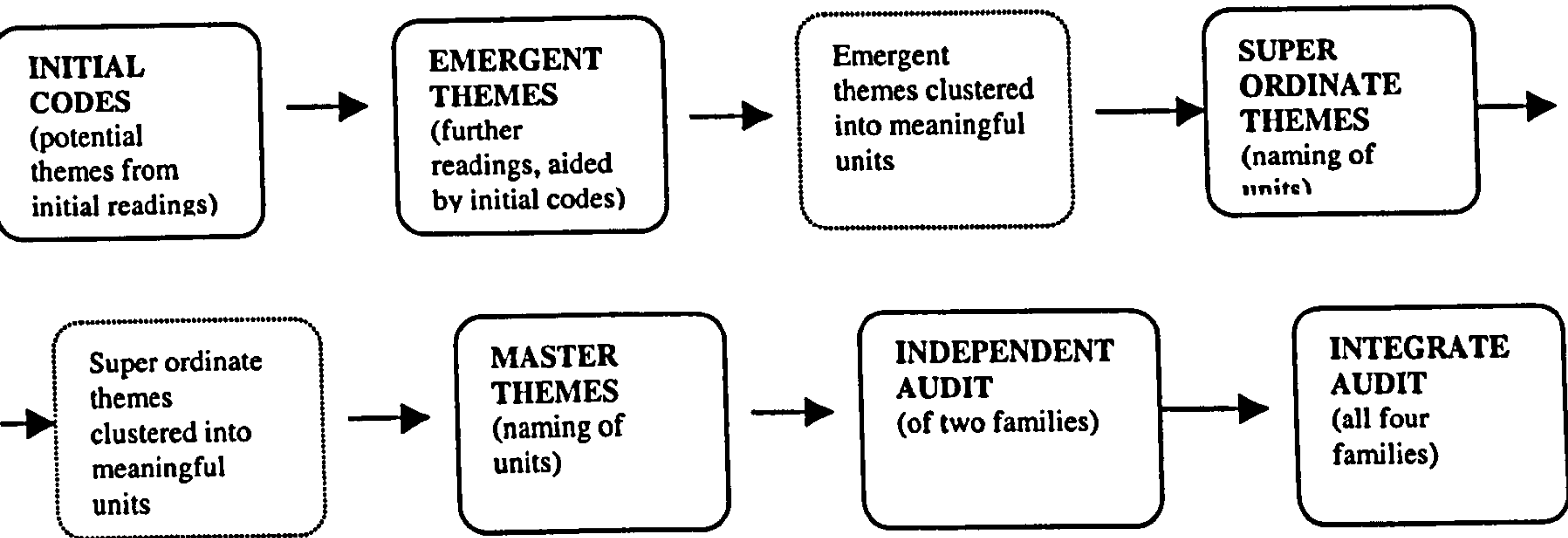
### Data Analysis

The interview transcripts were analysed individually using Interpretative Phenomenological Analysis (Osborn and Smith, 1998; Smith, Jarman and Osborn, 1999). A brief diagrammatic illustration of the analytical process is given in Figure 1, with a more detailed one, unfold the back page . The following procedure was applied:



- a) Interview transcripts were read and re-read a number of times. Audiotapes of the interviews were also listened to a number of times. Preliminary interpretations of the data were made and notes were made of potential themes (initial codes) in the left-hand margin of the transcripts (see Appendix 9 for a worked example).
- b) The text was re-read and more abstract codes, capturing the essential quality of a more general concept, were developed. These emergent themes were organised in the right-hand margin of the transcripts, and were influenced by the initial codes. There were no omissions or selection of data.
- c) Connections between the emergent themes were found, to form clusters.
- d) The clusters of themes were organised by making meaningful statements about them with super ordinate themes. These themes were checked with the transcript to ensure the quotes worked for the data.
- e) The super ordinate themes were clustered into meaningful groups and named, producing master themes. The transcript was checked to make sure the themes fit the quotes.
- f) Each interview was analysed separately, with no constructs predicted in advance. Smith, et. al. (1999) suggest two ways to proceed when analysing a number of individuals' transcripts. The first is using the main theme list from the first interview to begin the second analysis, looking for more instances of the themes, and identifying new themes. The second one the present author employed, was to begin the analytical process anew with every interview. A consolidated list of main themes was produced after the analysis of all interviews was completed.
- g) The analytical process, from the stage of raw data up to final themes, was audited independently by two auditors (see Independent Audit, p30). Their evaluations were integrated into a final version of the analysis of all four families.

**Figure 1.** Illustration of the Interpretative Phenomenological Analytical process



*Note.* The arrows indicate the sequence of the analytical process.

**Ethics**

Ethical approval was gained from the Local Research Ethics Committee to conduct the study (Appendix 6). In cases where parents had legal joint responsibility of the child with the local authority, permission was obtained from the relevant manager. To ensure anonymity, names were changed in this report.

Wider ethical issues arise from the research, such as the family experience of participating in the accumulation of the data. Multi-problem families could potentially experience the research as intrusive rather than ultimately helpful to them, due to the involvement of several agencies and professionals. Participation was voluntary and separate to the family therapy they were offered at the clinic. These two points were emphasised and repeated, with the family having the option of withdrawing from the research at any time during it. The research interviews were not long in duration, to minimise the impact on the family’s time. The nature of the research questions, which focussed on the therapist’s interventions, were not expected to increase the focus and pressure on the family. It was felt that it might in fact be encouraging for the family, as they would have the opportunity to express their views

on how the therapist was working and therefore could be experienced as collaborative. If the family expressed discomfort (or worse) or the therapist picked up on it, this would be discussed and (if appropriate) the option of withdrawal from the research would be put forward by the author.



# RESULTS

The results are divided into five sub-sections. Section one presents basic case details and a brief case history of the children and families involved in the research. The names of the families have been changed. The nature of the alliance events identified by the families is summarised in two tables in Section two. Section three presents detailed examples of the analytical process. Section four describes the master themes in detail. As the method of data collection and analysis for the four family therapy cases was standardised, cross comparison between them was possible. The results of the analysis for the family and child interviews and structured therapist commentary are presented separately, but in such a way as to make comparison between them as easy as possible. In Section five the results of the quantitative alliance scales are presented.

## Section One: Case Histories

The basic case details are presented in Table 2.

**Table 2.** Basic case details of all four families

Case Details	Adams	Baker	Chase	Dune
Age (referred child)	13	5	11	11
Gender (referred child)	male	male	female	male
Number of FT sessions	5	7	5	6
Family attendance:				
Session 1	M & RC	M,P & RC	M,RC & 3xB	M,SF & RC
Session 2	M,RC & B	M & P	M,RC & 3xB	M,SF & RC
Session 3	M,F & RC	M & P	M,RC & 3xB	M,SF & RC
Session 4	M,RC & B	M & P	M,RC & 3xB	M,SF & RC
Session 5	M,F, & RC	M & P	M,RC & 3xB	M & RC
Session 6		M,P & RC		M,SF,RC & S
Session 7		M,P & RC		

*Note.* Abbreviations: FT=Family Therapy; M=Mother; F=Father; P=Partner; SF=Stepfather; RC= Referred Child; B=Brother; S=Sister; 3x=three of.

### *Adams Family*

The referred child, a boy of thirteen years of age, was referred for his anger outbursts. Social services had become involved due to the physical danger he was putting himself and other family members in during some of these episodes. They completed a child protection investigation. He came with his mother to the initial appointment, with an older brother and his father attending some of the later sessions. The boy found it very difficult to participate in the family sessions. He seemed sullen and withdrawn and lacking in confidence. His expressions of anger seemed to be rooted in family circumstances which over the last two years had become progressively more difficult and strained. His father had developed a progressive and chronic medical condition which was increasingly incapacitating him, affecting his emotional well being as well. The condition and its consequences in terms of roles and support affected the whole family, including the boy.

### *Baker Family*

The referred child, a boy of five years, was referred to the service by the social worker. The boy was on the child protection register. Support was requested for the mother and partner (not the child's father), to help them in managing his behaviour at home, as he was 'uncontrollable' and 'disobedient' and they found it impossible to parent him effectively. The child attended the first session, but thereafter only attended the sixth and seventh session, due to the nature of the material that was dealt with in the other sessions. The child appeared timid and confused and showed some signs of developmental delay. The mother had learning disabilities and had had an emotionally traumatised past, including physical and emotional abuse. The home situation transpired to be chaotic, with members of the extended family moving in and



out of the home and at one time, a fear that one member who was a past abuser, had been visiting. This was never established. Concern heightened for the author during the sessions for the well-being of the child, as well as the high level of need of the mother, which it appeared were not being addressed currently by the social services.

### *Chase Family*

A clinical colleague of the author referred the third family. The referred child, an eleven year-old girl, was experiencing difficulties at home and at school, including fighting at school and with her siblings. She had a male twin and two younger brothers, aged nine and two. The children had been on the child protection register due to the domestic violence of their father towards the mother and physical abuse by their mother towards the children. The mother separated from the father and after a period, the children were taken off the register. The mother continued to have support by social services, health and voluntary services. According to the author's impression from the sessions, the girl was feeling overwhelmed and confused by her continuing contact with her father, her past experience of the domestic violence and her current feelings towards her parents. The mother felt helpless in understanding and supporting her daughter, with a resultant interaction of blaming and negative spiraling.

### *Dune Family*

This eleven year-old boy was referred by the school due to contact difficulties with his natural father, with whom he did not live. The sessions were attended by him, his mother and stepfather and on one occasion, his sixteen year-old sister. His parents had an acrimonious split a number of years previously, due to domestic violence. The



boy’s elder sister, who was eighteen, was in care. He was very reluctant to attend, only doing so on the insistence of his mother and stepfather. He seemed very anxious and withdrawn, refusing to talk or participate in the sessions. It emerged that he was fearful that his father would kidnap him. He was uncertain as to the stability of his present living arrangements and had a fear of being taken into care, which compounded his fear of disclosing.

**Section Two**

The alliance events identified by the families consisted of seven particular vignettes of a session and on three occasions, the whole session. Six of the events were positive alliance experiences and four consisted of positive and negative elements (Table 3).

**Table 3.** Nature of alliance events identified by the families

Event	Adams	Baker	Chase	Dune
Vignette	+/- +	+	+ +/-	+ +
Whole session		+/- +/-		+

*Note.* + indicates a positive alliance  
- indicates a negative alliance  
+/- indicates both positive and negative aspects to the alliance  
Each symbol (or pair of symbols divided by a forward slash) indicates an alliance event.

Table 4 gives descriptions of four alliance events within the family therapy session, with a description of all alliance events given in Appendix 7. The illustrative quotes come from the family therapy sessions themselves and not from the research interviews. A range of events are presented in the table, including events identified by the parents, the referred child and/or other family members. The adult members of the families were found to identify the alliance events more often, with three of the total nine events co-identified by the referred child. With the remaining six events,

the child did not contribute to their identification. When the parents identified the event, they seemed in agreement with one another regarding its prominence.

Agreement also seemed to occur when the entire session was identified as either positive, or containing both positive and negative elements. Table 4 illustrates one event where there were differences between individual family members' experiences

**Table 4. Illustrative descriptions of four alliance events**

FAMILY & SESSION	IDENTIFIED BY	DESCRIPTION OF EVENT	ILLUSTRATIVE EXTRACT
Adams – session 2	Mother & older brother of RC (Event experienced with positive and negative aspects)	In this section of the session RC's temper outbursts were discussed in the light of family circumstances, how different members were affecting and interacting with one another and individual temperaments. (at 44-48 minutes into 60 minute session)	T: is that right, RC, what your brother is saying? RC: yea, sometimes T: ...when your father asks you to do something and you can't do it then, he gets frustrated...and you can get as well.. RC: yea.. T: and you take it out on your father... B: or whoever is there....
Baker – session 4	Mother & Partner (Whole Session experienced with negative and positive aspects)	Mother and partner both felt that FT was not being helpful in changing RC's behaviour, due to lack of advice given by the therapist regarding it. Partner expressed exasperation in the lack of improvement in the parental relationship, family circumstances and professional services received. Mother presented as low self-esteem and fearful of services.	P: the SW tells us we need to promise RC things to do for us... M: yea, she does.... P: I don't agree with that... M: you shouldn't have to get him to do things like that, as a five-year-old.. T: you'd like him to obey.... M: yea...everyone is telling us different things....
Chase – session 4	Referred child, Twin brother & Mother (Event experienced as positive by the children and positive and negative by the mother)	The RC and her twin brother enacted a concrete conflict situation between them by a "football game". They were able to work through their difficulties and come to an agreement, resolving the issue to their satisfaction, with the help of the therapist as the "referee". (at 39-49 minutes into 60 minute session)	T: you both say what you're not happy with, now how do you think you can help? B: by not saying nasty things to her (RC). RC: and not....(children argue with one another) T: remember that I 'm the referee.. RC: to know he's (B) busy sticking up for me....
Dune – session 4	Mother & Stepfather (Event experienced as positive by both)	Through the aid of visual scales (of anger and fear), and coloured pencils, the RC expressed his feelings. Both parents were surprised at RC's fear of being kidnapped by his natural father and the pervasiveness of his fear and feeling of lack of safety. (at 24-29 minutes into 60 minute session)	T: do you feel safe here (to RC)? RC: (shakes his head, while drawing) T: you're still scared.... RC: (nods his head) T: it seems as if his fear...could be a lot of the time...is that right (RC)? RC: (nods his head, drawing) M: when I'm at home with RC, he constantly asks when SF is going to come back....

*Note.* Abbreviations: FT=Family Therapy; RC=Referred Child; T=Therapist; B=Brother; M=Mother; SF=Stepfather; P=Partner; SW=Social Worker



of the events. The children experienced the event as positive whereas the mother experienced the event as both negative and positive.

Family members participated fully in the family interviews, which included two parents in all but the Chase family and in the case of the Adams family, an older sibling. The referred child made notable contributions in the three alliance events they co-identified, two of which were in the Chase family and one in the Adams family. In the other alliance events the participation of the referred child was either negligible or minimal in terms of verbal expression or communication.

### **Section Three: Process of Analysis**

The process of analysis will be illustrated by going through the interpretative phenomenological analysis of one interview transcript from the Chase family (see p34 for method or, for a diagrammatic presentation, unfold back page).

During the first readings of the transcripts initial codes (which were potential themes) were written down next to the text, in the left-hand margin. From subsequent readings of the text and the early categorisation of initial codes, emergent themes were developed. Codes were thus formed into themes, aided by the author's interpretations. Table 5 illustrates extracts of text with the initial codes on the left-hand margin and emergent themes on the right-hand margin, as on the original transcripts. The full transcript of the illustrated interview with all the themes is presented in Appendix 8.

After the emergent themes were identified, they were clustered together into meaningful groups and named, which were the super ordinate themes. The emergent themes in Table 5 were selected for illustration as they were clustered together to form the super ordinate theme described as "interactive child play facilitates



emotional expression and behavioural coping strategies”. This cluster can be seen in Table 6.

**Table 5.** Text extracts with initial codes and emerging themes (from session 4 - family interview 2 - with Chase family)

Initial Codes	Text Extracts	Emergent Themes
Communication and understanding	R: how did you find it (“football game”)* (to children)? B: I thought it was good. M: B knows what RC thinks now..... understanding each others’ feelings	Interactive child play facilitates: - exchange of views - understanding
Turn-taking and space to express	RC: I found it really helpful, did you B? B: I found it excellent...i think it was very good to talk..to each on one side and if I wanted to say something I could....	Game play aids child to have a voice
Communication better	B: RC, instead of arguing towards each other and she (RC) even gave me something.	Expression of difficult feelings
Better communication versus withdrawal	B: because in a football game walk around each other to each other’s goal but if I was like the more opportunity that I had the more I would have wanted to walk this way...I would have walked away from RC.	Develop coping strategies
Conflict versus compromise	B: and I was coming up towards the halfway line and she (RC) said like she’s defending herself in a way that she is saying no of course and the more speed you ( <i>she</i> ) are doing the more I am going to come back as I move forward.	Processing of behavioural options in concrete conflict situations
Self-value	RC: I find it helpful because we all get the time to talk, it’s more easier for us to talk, to discuss it, things that we can like, things that we can sort out.	Control over manner of expression gives value to child’s voice

*Note.* R=Researcher, B=Brother, M: Mother, RC= Referred Child. \* See Table 4 for description of Event.

**Table 6.** Emergent themes underlying a super ordinate theme

Emergent Themes	Super Ordinate Theme
Interactive child play facilitates: - exchange of views - understanding	Interactive child play facilitates emotional expression and behavioural coping strategies
Game play aids child to have a voice	
Expression of difficult feelings	
Develop coping strategies	
Processing of behavioural options in concrete conflict situations	
Control over manner of expression gives value to child’s voice	

In the same way, all the emergent themes were clustered and super ordinate themes were named. For an illustration of all the (clustered) emergent themes and super ordinate themes see Appendix 8. Table 7 lists all the super ordinate themes that were named from the clustered emergent themes of the interview.

**Table 7. Super Ordinate themes underlying Master Themes**

<b>Super Ordinate Themes</b>	<b>Master Themes</b>
Interactive child play facilitates emotional expression and behavioural coping strategies	Child-centred interactive play techniques (visual aids)
Skills in communicating with children: <ul style="list-style-type: none"><li>- questioning technique</li><li>- nature of language</li></ul>	Positive relationship between developmentally appropriate communication skills with children and client motivation/self-mastery
Positive outcome motivates parent and children and enhances self-esteem	
Supportive and curious therapist	
Sharing responsibility for difficulties	Individual to systemic meaning (systemic approach)
Family loyalty versus emotional expression conflict becoming more flexible	Containment of family conflict and anxieties

*Independent Audit*

After completing the analyses of the four families, the transcripts and analyses of two families were picked randomly for independent audit. The audit process was described in the Method section (p30). With the help of comments and subsequent modifications made in the analyses of the audited families, the analyses of the other remaining two families were modified, where necessary.

Following the separate discussions the author had with the auditors, differences in the types of comments and feedback given by the two auditors were found. The auditor who was a research tutor identified more disconfirmations of themes than the clinician (per interview and in total). With the former auditor the disconfirmations occurred particularly at the first level of theme development, i.e. identifying emergent themes from the transcript. The auditor identified some of the author’s themes as too negatively connotated, suggesting positive alternatives. The auditor who was a clinician made no such suggestions.

Extracts of one analysis (Dune family) will illustrate the audit trail and results of the audit process. The full interview transcript and accompanying table of themes (both the original and modified versions of the table), with the audit trail apparent, can be found in Appendix 9. This particular audited interview was selected as it best



seemed to represent the types of adjustments made as a result of the audits as a whole. This included the adjustments made to the audited analyses and those of the remaining two families that were not audited.

**Table 8.** Illustration of independent audit – from text to emergent themes

Text extracts	Emergent themes	Type of adjustment
SF: you got him to admit the scared part	Success in FT (theme confirmed)	None
SF: ...it will help me understand him a little bit more....	Underconfident in relation to child <i>FT helps understand child*</i>	More positive interpretation felt to be more accurate, thus theme adjusted
SF: ...and so you are helping him it's now down to coming here...	Expectation of progress (theme confirmed)	None
R: ..coming today has really affected you coming to family therapy? M: yes SF: yes	Need reassurance <i>Positive about FT</i>	More positive interpretation. Also, the researcher recalled the affective tone of the parents' answers when interpreting the text, thus theme adjusted where tone not taken into account.
SF:...every time we come here it's a bit from the last session to this one something's come up	Strategic FT <i>Faith in FT</i>	Some researcher bias, as opinion as family therapist aided interpreting parent's cryptic answer, thus theme adjusted.
SF: ...the next one ( <i>session</i> ) something else will come out.	Power to therapist <i>Expectation of further progress - positive</i>	Inaccurate interpretation revealing some researcher bias, thus theme adjusted.

*Note.* \*Emergent themes – theme written in normal font is the original theme, with that in italics the adjusted theme.  
Abbreviations: SF=Stepfather; M=Mother; R=Researcher; FT=Family Therapy

The example in Table 8 illustrates disconfirmations of emergent themes (written alongside the text extracts) interpreted by the author and the type of adjustment that was made as a result of the independent audit. Two confirmations are also included, as they formed part of the new cluster of emergent themes. The last example of disconfirmation in Table 8 presents a change in the emergent theme, from “Power to the therapist” to “Expectation of further progress – positive”. The former emergent theme (i.e. as interpreted by the author) represented an interpretation that suggested some researcher bias. The latter emergent theme seemed to represent a more accurate interpretation of the interview transcript.

Table 8 illustrates four of the seven emergent themes that were disconfirmed and adjusted out of a total of twenty-nine emergent themes from the whole interview.



They represented the types of adjustments made in the independent audit as a whole. Table 9 presents the six emergent themes that were subsequently clustered and renamed the super ordinate theme “Positive view of Family Therapy – progress made (effective)”. A further interpretation led to a new master theme “Benefit”.

**Table 9.** Illustration of independent audit – from emergent themes to master theme

Emergent themes	Super ordinate theme	Master theme
Success in FT	Positive view of FT – progress made (effective)	Benefit
FT helps understand child		
Expectation of progress		
Positive about FT		
Faith in FT		
Expectation of further progress - positive		

*Note.* Abbreviation: FT=Family Therapy

Other minor changes to the wordings of super ordinate themes in this interview represented more succinct descriptions and led to no changes in their meanings. These are illustrated in Appendix 9.

**Section Four: Master Themes**

An overview of the master themes that emerged from the analysis of the family, child and therapist interviews will be given. This is followed by the presentation of each master theme separately.

*Overview*

The interviews were analysed separately with the consequence that a large number of master themes emerged when a list of their total was made. However, many of the master themes were describing very similar concepts. As they would lose none of their meaning, the names of the master themes were streamlined. The result was a more succinct list of themes. However, to enable the reader to follow the idiosyncracies and similarities that underlie the master themes for the different

families and the three types of interviews, their super ordinate themes (level just below master themes) are presented separately from one another. A high level of abstraction is reached in the analytical process when it reaches the stage of master themes. To present every master theme, examples of clustered emergent themes underlying an illustrated super ordinate theme are presented. In addition, illustrative quotes from the transcripts are used (see pull-out page for diagram of analytical process).

Table 10 shows the master themes that emerged from the family and child interviews for the four families, with Table 11 those from the therapist interview.

Table 10. Master themes (Family and Child interviews)

Master theme	Family interview	Child interview
1. Child therapy stance / technique	Adams/ /Chase/Dune	Adams/Baker/Chase/Dune
2. Child communication style	Adams/ /Chase/Dune	Adams/Baker/Chase/Dune
3. Individual to systemic understanding	Adams/Baker/Chase/Dune	Adams/ /Chase/
4. Working alongside	Adams/Baker/ /Dune	
5. Being heard	/Baker/Chase/	Adams/ /Chase/Dune
6. Not being heard	/Baker/Chase/Dune	/Baker/
7. Safety	/Dune	/Baker/ /Dune
8. Benefit	/Baker/Chase/Dune	
9. Organisation of session	/Dune	
10. Limits of IPR procedure	/Baker/	

Table 11. Master themes (Structured therapist commentary)

Master theme	Family
1. Child therapy stance / technique	Adams/ /Chase/Dune
2. Child communication style	/Dune
3. Individual to systemic understanding	Adams/Baker/ /Dune
4. Working alongside	Adams/Baker/Chase/Dune
5. Being heard	Adams/Baker/ /Dune
6. Not being heard	/Baker/
7. Safety	/Baker/Chase/Dune
8. Benefit	Adams/Baker/
9. Organisation of session	Adams/Baker/Chase/Dune

Note. The master themes are allocated the same numbers as in Table 10, to make comparison easier.



1. Child Therapy Stance / Technique

This master theme incorporates knowledge and skills of stance and techniques of engaging and working therapeutically with children to enable their full participation in the family therapy process.

Table 12. Super ordinate themes for the master theme – Child therapy stance / technique

	Adams	Baker	Chase	Dune
Family interview	<ul style="list-style-type: none"><li>- Developmentally sensitive technique</li><li>- Child therapy technique</li><li>- Indirect communication aids</li><li>- Active involvement of child in conversation</li><li>- Child needs help in self-expression</li></ul>	(No themes)	<ul style="list-style-type: none"><li>- Child interactive play technique aids self-expression and coping strategies</li></ul>	<ul style="list-style-type: none"><li>- Confidence in therapist's ability with child</li><li>- Child therapy technique</li></ul>
Child interview	<ul style="list-style-type: none"><li>- Therapist supportive by helping child communicate</li><li>- Active participation in FT</li><li>- Difficult to talk to Therapist</li></ul>	<ul style="list-style-type: none"><li>- Emotionally sensitive approach</li></ul>	<ul style="list-style-type: none"><li>- Child therapy techniques</li><li>- Self-expression</li><li>- Knowledge and skills to help child express</li><li>- Tentative interpretation</li></ul>	<ul style="list-style-type: none"><li>- Non-directive child technique</li><li>- Self-expression difficult</li><li>- Emotional state</li><li>- Tentative interpretation</li></ul>
Therapist comments	<ul style="list-style-type: none"><li>- Simple reflection</li><li>- Child therapy technique</li><li>- Tentative interpretation</li></ul>	(No themes)	<ul style="list-style-type: none"><li>- Child-centred interactive play technique (boosts confidence, self-mastery, -value, ability and permission to express, scaffolding)</li><li>- Model of communication with child</li><li>- Flexibility in Therapist role</li></ul>	<ul style="list-style-type: none"><li>-Child therapy technique</li><li>- Non-directive technique (visual)</li><li>- Child trauma and treatment</li><li>- Model of communication with child</li><li>- Developmental and emotional needs</li></ul>

Table 12 illustrates the super ordinate themes that underlay the master theme.

The format of this table attempts to make comparison as easy as possible both between what emerged from the analyses of the different families and what the family, child and therapist regarded as therapist factors (pertaining to this particular master theme) influencing the therapeutic alliance.

This theme emerged in all four families in the child interview, while in the same three families in the family interview and therapist commentary. The absence of this master theme in the family interview of the Baker family should be taken in



context of the referred child only attending the three of the seven sessions (first, sixth and seventh sessions).

Section three (p44) gives a detailed example of this master theme as it emerged from a family interview with the Chase family. The super ordinate themes that emerged from the child interviews could be summarised as the child's need for the therapist to support his/her communication and self-expression in age- and emotionally appropriate ways. The following quote from a family interview with the referred child of the Dune family illustrates his experience (super ordinate theme – Child therapy technique)(detailed illustrations of two child interviews in Appendix 10):

*SF: You got him to admit the scared part. Just with the chart (a chart of feelings on scales of 0-10, child needed to indicate with a coloured pencil his feelings) but as before we'd ask him and would just give you a shrug of his shoulders and you're bringing him out of his shell.*

Self-expression was commonly identified as difficult and the use of more indirect approaches helpful, in the child, family and therapist interviews.

## **2. Child Communication Style**

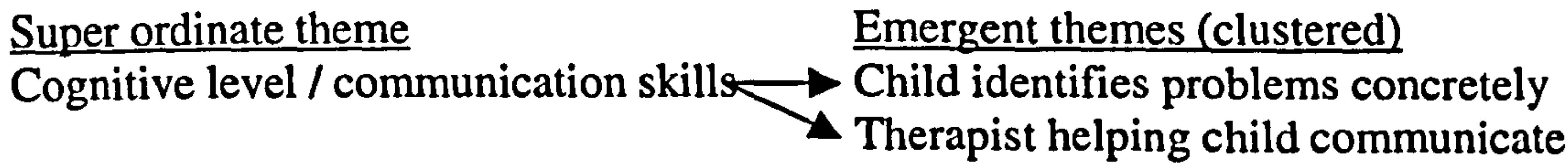
This master theme refers to an awareness of children's style and developmental level of communication and the impact this has on efforts the therapist makes to engage with and involve them in family therapy. Table 13 presents the super ordinate themes that underlay this master theme in the analyses of the different groups of participants.

This theme emerged in the child interview in all four families and in three of the four families in the family interview. Child communication style emerged in only one family in the therapist commentary. The child is indicated, by the emergence of

Table 13. Super ordinate themes for the master theme – Child communication style

	Adams	Baker	Chase	Dune
Family interview	- Relevant communication skills (concrete understanding) - Language – simple and direct	(No themes)	- Communication skills (questioning technique and nature of language)	- Child struggling to communicate
Child interview	- Cognitive level and communication skills	- Developmentally sensitive approach - Developmental level of understanding (concrete)	- Cognitive level - Age-appropriate communication - Loss and self-expression	- Developmentally appropriate language/communication
Therapist comments	(No themes)	(No themes)	(No themes)	- Confidence in child communication - Develop alliance and self-value

the master theme in all families, to find the level and style of communication taken by the therapist important in engagement and participation, as well as the pace of therapy. This can be illustrated further by the cluster of two emergent themes that underlay the super ordinate theme “Cognitive level and communication skills” for the Adams family’s child in his child interview:



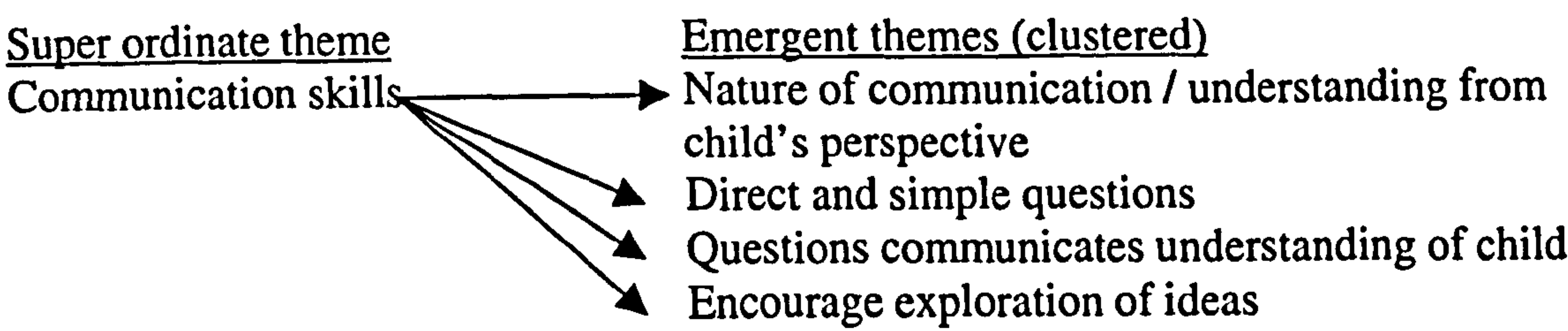
An illustrative quote from a family interview with the Adams family (super ordinate theme – Language – simple and direct):

R:     *What did I do as therapist that was helpful?*

M:     *You asked him very simple questions, you listened and then put it across in a way that RC could understand and also responded to...you took things that were said around during the therapy, and give it to him in a way that he could listen and accept it, and then he gave a clear and his own response to it, he really needed someone who could communicate on his level, who understood him.*



Another example from a family interview with the Chase family illustrates what this master theme meant for them. The cluster of four emergent themes that underlay their super ordinate theme “Communication skills (questioning technique and nature of language)” was the following:



An illustration of a child interview quote is appended (Appendix 10).

### 3. Individual to Systemic Understanding

The master theme “individual to systemic understanding” could be defined as a process in the therapy that led from an individualised and often blaming understanding of the referred child’s problems to a position where a more systemic exploration and understanding occurred, in which family members played a part.

Tables 14 – 17 illustrate the super ordinate themes that underlie this master theme. The super ordinate themes that emerged along the course of therapy, in other words, in the second, fourth and sixth therapy sessions, are presented in sequence. By this format the time sequence involved in the shift in meaning could be illustrated.

**Table 14.** Super ordinate themes for the master theme – Individual to systemic understanding (Adams family)

ADAMS	FT Session 2	FT Session 4
Family	- Shift of responsibility from child to family - Increasing communication within family	- Systemic understanding of child's problems
Child*	- Weight of blame on child	- Vulnerable (continued) to scapegoating - Systemic understanding and self-confidence (child)
Therapist	- Relieving pressure of blame (child)	- Restorying child's experience within broader family context

*Note.* \*The Child interviews were held following session 3 and session 5.



**Table 15.** Super ordinate themes for the master theme – Individual to systemic understanding (Baker family)

BAKER	FT Session 2	FT Session 4	FT Session 6
Family	<ul style="list-style-type: none"><li>- Marital problems limit systemic understanding</li><li>- Tentative interpretation of systemic roles</li><li>- Behavioural change vital, conversation insufficient</li><li>- Parent unable to deal with parental issue</li><li>- Father skeptical of mother's ability to deal with systemic issue</li></ul>	<ul style="list-style-type: none"><li>- Discrepancy – understanding of child's behaviour (Father – systemic; Mother – individual/blames)</li></ul>	<ul style="list-style-type: none"><li>- FT stuck – systemic issue unresolved</li></ul>
Child*	(No themes)	(No themes)	(No themes)
Therapist	<ul style="list-style-type: none"><li>- Parent's learning disability and ability to link behaviour to systemic issues</li></ul>	(No themes)	(No themes)

*Note.* \*The Child interviews were held following session 6 and session 7.

**Table 16.** Super ordinate themes for the master theme – Individual to systemic understanding (Chase family)

CHASE	FT Session 2	FT Session 4
Family	<ul style="list-style-type: none"><li>- Conflict – family loyalty versus expression</li><li>- Style of communication – blame and defensive</li><li>- High parent expectations for behaviour</li><li>- Parent feels ineffective</li><li>- Child feel insufficient parent support</li><li>- Better communication and understanding and competence as parent</li></ul>	<ul style="list-style-type: none"><li>- Sharing responsibility</li></ul>
Child*	<ul style="list-style-type: none"><li>- Family communication (unsatisfying)</li></ul>	<ul style="list-style-type: none"><li>- Uncertain of parent support</li></ul>
Therapist	(No themes)	(No themes)

*Note.* \*The Child interviews were held following session 3 and session 5.

**Table 17.** Super ordinate themes for the master theme – Individual to systemic understanding (Dune family)

DUNE	FT Session 2	FT Session 4	FT Session 6
Family	<ul style="list-style-type: none"><li>- Scapegoating of child</li><li>- Parents feel ineffective and blame child</li></ul>	<ul style="list-style-type: none"><li>- Parent – child communication (blame and defensive)</li><li>- Focus change (behaviour to meaning behind it)</li></ul>	<ul style="list-style-type: none"><li>- FT – alternative style of communication</li><li>- Individual to systemic view (shift of responsibility away from child)</li></ul>
Child*	(No themes)	(No themes)	(No themes)
Therapist	<ul style="list-style-type: none"><li>- Exploration and shifts in meanings/views</li></ul>	(No themes)	<ul style="list-style-type: none"><li>- Individual and systemic understanding</li><li>- Shift from individual to systemic meaning</li></ul>

*Note.* \*The Child interviews were held following session 3 and session 5.

The master theme emerged in all four families in the family interview as well as at every stage of therapy illustrated (as presented in Tables 14 – 17). In the child interview the master theme emerged in two of the four families and on emergence, it was represented in the first and second stage. The theme also emerged in three of the four families in the therapist commentary. An example in a shift in meaning at the

more concrete or specific level of emergent themes and quotes in the analysis of a family interview for the Dune family is illustrated in Table 18.

**Table 18.** Shift in meaning – Cluster of emergent themes underlying two super ordinate themes (Dune family)

	Session 2	Session 4
Super ordinate theme	Scapegoating of child	Focus change (behaviour to meaning behind it)
Emergent themes (clustered)	<ul style="list-style-type: none"><li>- Defensive &amp; blaming</li><li>- Pressure and responsibility</li><li>- Lack of support for child</li></ul>	<ul style="list-style-type: none"><li>- Shift from blame to understanding of child</li><li>- Parent supportive of child</li><li>- Parent support rather than blame</li></ul>
Illustrative quote: Pressure and responsibility (emergent theme)	SF: ..and the longer he's (RC) like it the more it upsets everyone else and then...it upsets me...	
Illustrative quote: Shift – blame to understanding (emergent theme)	SF: At least he's opened when he's said nothing for weeks and that he was scared all the time...	

4. Working Alongside

This master theme describes the attempt by the therapist to collaborate with the family in what their needs in therapy are and converging these with the therapist's

**Table 19.** Super ordinate themes for the master theme – Working alongside

	Adams	Baker	Chase	Dune
Family interview	<ul style="list-style-type: none"><li>- Inclusion of absent and silent family members</li><li>- Active involvement of child in therapy</li><li>- Space for family to discuss current issues</li></ul>	<ul style="list-style-type: none"><li>- Therapist actively supports issues brought by parents</li></ul>	(No themes)	<ul style="list-style-type: none"><li>- Defensive parenting style</li><li>- Parents working with/following on example of Therapist (to help child)</li><li>- Parenting techniques (goal agreed)</li></ul>
Child interview	(No themes)	(No themes)	(No themes)	(No themes)
Therapist comments	<ul style="list-style-type: none"><li>- Inclusion of absent members</li><li>- Active involvement of child in therapy</li><li>- Reflective summarising of collective family experience</li><li>- Therapist work at family's pace - checking</li></ul>	<ul style="list-style-type: none"><li>- Collaborative</li></ul>	<ul style="list-style-type: none"><li>- Collaboration (balance needs of therapist and family in initial stage of therapy – info. collation vs problem resolution)</li></ul>	<ul style="list-style-type: none"><li>- Collaboration / partnership</li><li>- Working alongside family</li><li>- Address most pressing needs of family – flexibility</li><li>- Empowering parents in child techniques (communication and support)</li><li>- Working in partnership with parents</li></ul>



own aspirations and expectations (see Table 19 for all super ordinate themes).

This theme emerged in all but the Chase family in the family interview and in all families in the therapist commentary. However, the theme did not come up at all in the child interview. The meaning of this master theme for the Adams family (from the family interview) is further illustrated (in Table 20) by the cluster of emergent themes that underlie one of their super ordinate themes and an illustrative quote.

**Table 20.** Cluster of emergent themes underlying super ordinate theme – Adams family

Super ordinate theme	Cluster of emergent themes
Active involvement of child in therapy	<ul style="list-style-type: none"><li>- Referred child’s contributions/views valued</li><li>- Difficult to engage with referred child</li><li>- Therapist needs to help child express himself</li><li>- Direct participation of child in conversation is vital in understanding him</li></ul>
Illustrative quote: Therapist needs to help child express himself (emergent theme)	R: What was it that I as therapist did that was useful or not? M: RC isn’t getting enough time to say something..maybe more should be headed towards him

**5. *Interest / Being Heard***

This master theme includes the non-specific factors of therapy and refers to the family members experiencing the therapist as having a genuine interest in them and what they bring to therapy, that their opinions and needs are being heard (see Table 21 for all super ordinate themes).

This theme emerged in three of the four families in the child interview and therapist commentary and in two families in the family interview. Table 22 illustrates what the Baker family meant by the super ordinate theme “Felt valued and understood” in a family interview, with illustrative quotes.



Table 21. Super ordinate themes for the master theme – Interest / being heard

	Adams	Baker	Chase	Dune
Family interview	(No themes)	- Heard / listened to - Non-judgmental attitude - Felt valued and understood - Genuine interest / curiosity - Therapist listens	- Supportive and curious Therapist (of family members' views)	(No themes)
Child interview	- Child feels supported by Therapist	(No themes)	- Empathy / understanding - Unconditional acceptance - Reflective responding	- Empathy / understanding
Therapist comments	- Empathic responding - Curiosity in family's meanings and understanding - Reflective summarising - Empathy – meanings and experiences	- Feel valued / respected - Empathy / understanding	(No themes)	- Listens

Table 22.Cluster of emergent themes underlying super ordinate theme (Baker family)

Super ordinate theme	Cluster of emergent themes
Felt valued and understood	- Empathic understanding of family members - Value of Family Therapy – their views and problems being heard
Illustrative quote: Value of Family Therapy (emergent theme)	R: Did I do anything that wasn't useful? P: Not really...you listen to us...
Illustrative quote: Heard and non-judgmental (emergent theme)	P: You've listened, asked us our opinions, we've been coming here for a while now. R: What have I as therapist done that has been helpful today? P: You listen to us and don't judge us, not taking sides, not her (M) side nor mine.

6. Not Being Heard

This theme describes the experiences the families have had and continue to have of professional services not listening to their needs and not fostering a relationship of collaboration (see Table 23 for all super ordinate themes).

Table 23. Super ordinate themes for the master theme – Not being heard

	Adams	Baker	Chase	Dune
Family interview	(No themes)	- Feel unheard / ignored by professional network	- Invasion of privacy – fear and discomfort (Services) - Social comparison and sense of inferiority	- Parents feel powerless and subjugated in relation to services (Social and Health)
Child interview	(No themes)	- Lack of protection	(No themes)	(No themes)
Therapist comments	(No themes)	- Inadequate professional services - High level of unmet need - Ineffective working relationship with wider services	(No themes)	(No themes)

The theme came up in three of the four families in the family interview and once in both the child interview and therapist commentary. This theme thus seems of importance for the families, ranging from a significant power imbalance between them and services to a feeling of social inferiority. An illustration of the emergent themes underlying the super ordinate theme “Invasion of privacy – fear and discomfort (Services)” in Table 24 indicates what this master theme meant for the Chase family in a family interview.

Table 24. Cluster of emergent themes underlying super ordinate theme (Chase family)

Super ordinate theme	Cluster of emergent themes
Invasion of privacy – fear and discomfort (Services)	<ul style="list-style-type: none"><li>- Discomfort – opening up of family issues</li><li>- Inappropriate – private issues public</li><li>- Discomfort – discussing private issues</li><li>- Embarrassment – private issues</li><li>- Family’s privacy</li></ul>
Illustrative quote: Discomfort – opening up of family issues (emergent theme)	M: ...I mean I am having to open up about my home, my family, which I feel like...it’s difficult

7. Safety

This master theme incorporates two possible aspects of safety. The first is the vulnerability and lack of emotional and physical safety children could experience within their home environment and in their relationship with Services, which can

manifest in the therapy. It also includes the sense of safety the family as a whole experience within the family therapy setting (see Table 25 for all super ordinate themes).

Table 25. Super ordinate themes for the master theme – Safety

	Adams	Baker	Chase	Dune
Family interview	(No themes)	(No themes)	(No themes)	- Containing / holding environment - Safety of a structured setting (social rules)
Child interview	(No themes)	- Safety - Feels unsafe in family environment - Disorganised attachment with mother - High level of distress and anxiety - Unmet needs at home - Suspicion and fear of Services	(No themes)	- Child wary of FT setting - Physical safety – fears - Physical protection and emotional security - Containment with understanding
Therapist comments	(No themes)	- Containment of anxieties	- Containment of family anxieties and needs	- Containment

This theme emerged from the analyses of two families in the child interview, from one in the family interview and from three in the therapist commentary. In the child interview the issue of safety manifested in the child’s wariness of the

Table 26. Cluster of emergent themes underlying super ordinate theme (Child interview – Baker family)

Super ordinate theme	Cluster of emergent themes
Feels unsafe in family environment	- Confused and distressed by regular parental conflict - Feels need for protection from parents - Fears physical retribution for his behaviour - Fears a pending loss of a parent
Illustrative quote: Fears a pending loss of a parent (emergent theme)	RC: ...they (M & P) argue.. R: And what do you do then? RC: I shout at them...angry. R: Oh, and then what? Are you worried? RC: Dad goes away and doesn't come back.
Illustrative quote: Scared of FT – fear of being taken into care (emergent theme)	R: RC, do you think coming here can help you? RC: Ummm.....no. R: Why not? RC: I get taken away (into care).



therapeutic and mental health setting and services in general and their feelings of vulnerability in their home environment. In the therapist interviews the psychoanalytic term “containment” emerged in three families. The emergent themes and a quote underlying the super ordinate theme “Feels unsafe in family environment”, that came out of the analysis of the child interview with the Baker family, is illustrated in Table 26.

### 8. Benefit

This master theme describes the benefits of progress the families experience during therapy sessions as positively influencing their confidence in the therapist and motivating in therapy (see Table 27 for all super ordinate themes). Conversely, a lack of progress leads to a decrease in confidence in the therapist and is demotivating in therapy.

**Table 27.** Super ordinate themes for the master theme – Benefit

	Adams	Baker	Chase	Dune
Family interview	(No themes)	<ul style="list-style-type: none"> <li>- Weak parental alliance limits positive outcome</li> <li>- Lack of behavioural change in child</li> <li>- Unsure of effectiveness of FT</li> <li>- Threat of parental breakup</li> <li>- Despondency – FT not effected change</li> <li>- Continued powerlessness in managing child</li> <li>- High level of need in parent</li> </ul>	<ul style="list-style-type: none"> <li>- Positive outcome for child motivates and enhances self-esteem of parent</li> </ul>	<ul style="list-style-type: none"> <li>- Hope / faith in FT- confident in ability of therapist</li> <li>- Positive view of FT (helping child)</li> <li>- Positive view of FT (progress made)</li> <li>- Change in and effectiveness of FT for family</li> <li>- Increasing parents' skills and confidence with their child</li> </ul>
Child interview	(No themes)	(No themes)	(No themes)	(No themes)
Therapist comments	<ul style="list-style-type: none"> <li>- Personal benefit increased motivation and participation in FT</li> </ul>	<ul style="list-style-type: none"> <li>- Query suitability of FT approach</li> <li>- Threat of parent breakup</li> <li>- Unprocessed family trauma</li> <li>- High level of need in parent</li> <li>- Lack of progress in FT</li> </ul>	(No themes)	(No themes)

This theme emerged in three families in the analyses of the family interview, in two families in the therapist commentary and did not appear in the child interview. The most apparent difference in the nature of the cluster of super ordinate themes that emerged from the analyses of the families, particularly from the family interview, was between the Baker and the other families. Table 28 illustrates further what the analyses produced in terms of emergent themes clustered under the super ordinate theme “Despondency – FT not effected change” for the Baker family in the family interview. For the Chase and Dune families the super ordinate themes indicate that perceived improvements within therapy and outside of it for the referred child increased their self-confidence in the therapist and motivation for therapy. An illustrative quote from the family interview with the Dune family (super ordinate theme – Positive view of therapy (progress made):

SF: *...and it's like as every visit (session) is a step forward.*

M: *It's a step forward.*

Table 28. Cluster of emergent themes underlying super ordinate theme (Baker family)

Super ordinate theme	Cluster of emergent themes
Despondency – FT not effected change	<ul style="list-style-type: none"><li>- FT ineffective – not dealt with child’s behaviour</li><li>- FT ineffective – no changes in parental relationship</li><li>- Lack of progress in family environment</li><li>- Frustration – lack of progress in FT</li><li>- Parent feels unsupported by family and therapist</li></ul>
Illustrative quote: FT ineffective – no changes in parental rel’p. (emergent theme)	R: Has this session made a difference how you are with each other? P: No, not really, I am still in the same position (at home) and I still want the same (out of relationship).

9. Organisation of Session

This master theme encompasses the organisation a therapist could bring to the therapeutic setting, which includes providing structure, focus and strategy to agreed



upon overall goals of therapy and more specific in-session tasks (see Table 29 for all super ordinate themes). Some overlap can be noted with the theme “Safety”, particularly with the super ordinate theme such as “Safety of a structured setting – social rules” (see page 58).

**Table 29.** Super ordinate themes for the master theme – Organisation of session

	Adams	Baker	Chase	Dune
Family interview	(No themes)	(No themes)	- Lack of strategic focus	- Structure and focus helpful
Child interview	(No themes)	(No themes)	(No themes)	(No themes)
Therapist comments	- Active structuring of session around initially agreed goals - Structuring of session according to issues brought by family	- Provision of strategy, focus and structure crucial for FT - Focus for FT - Therapist’s supportive role in focussing on parent issue	- Focus and structure on agreed upon in-session tasks and overall goals - Provision of structure for in-session tasks	- Strategic approach

This theme emerged in the analyses of two families in the family interview and all four families in the therapist commentary. It did not come up in the child interview. The presence of this master theme was therefore largely down to the analyses of the therapist interview, where the active structuring of sessions according to agreed upon goals and in-session tasks was regarded as influencing the alliance.

Table 30 gives an account of the emergent themes that were clustered to form the super ordinate theme “Structure and focus helpful” for the Dune family in a family interview.

**Table 30.** Cluster of emergent themes underlying super ordinate theme (Dune family)

Super ordinate theme	Cluster of emergent themes
Structure and focus helpful	<ul style="list-style-type: none"> <li>- Focus on concrete event</li> <li>- Helpfulness of structure for listening/communication</li> <li>- Structure enhances freedom of expression in session</li> </ul>
<b>Illustrative quote:</b> Focus on concrete event (emergent theme)	SF: The part (of the session) where I actually stormed out of the house, that was useful we talked about.



## *10. Limits of IPR Procedure*

The usefulness and appropriateness of the IPR video-playback and interview procedure was brought into question with a parent with a learning disability, with the associated difficulties in adequate comprehension of the interview, including the cognitive ability necessary to participate successfully. The interview could also expose the parent again to traumatic and unresolved past issues.

The theme only emerged in the family interview of the Baker family. The three super ordinate themes that emerged were “Discomfort with video playback”, “Parent with learning disability” and “IPR interview creates double exposure to exacerbate losses”. An illustrative quote is (super ordinate theme – Parent with learning disability):

*R: What did I do as therapist that was useful?*

*M: Er...I don't really know to tell you the truth.*

*R: Anything I said or did?*

*M: I can't really remember.*

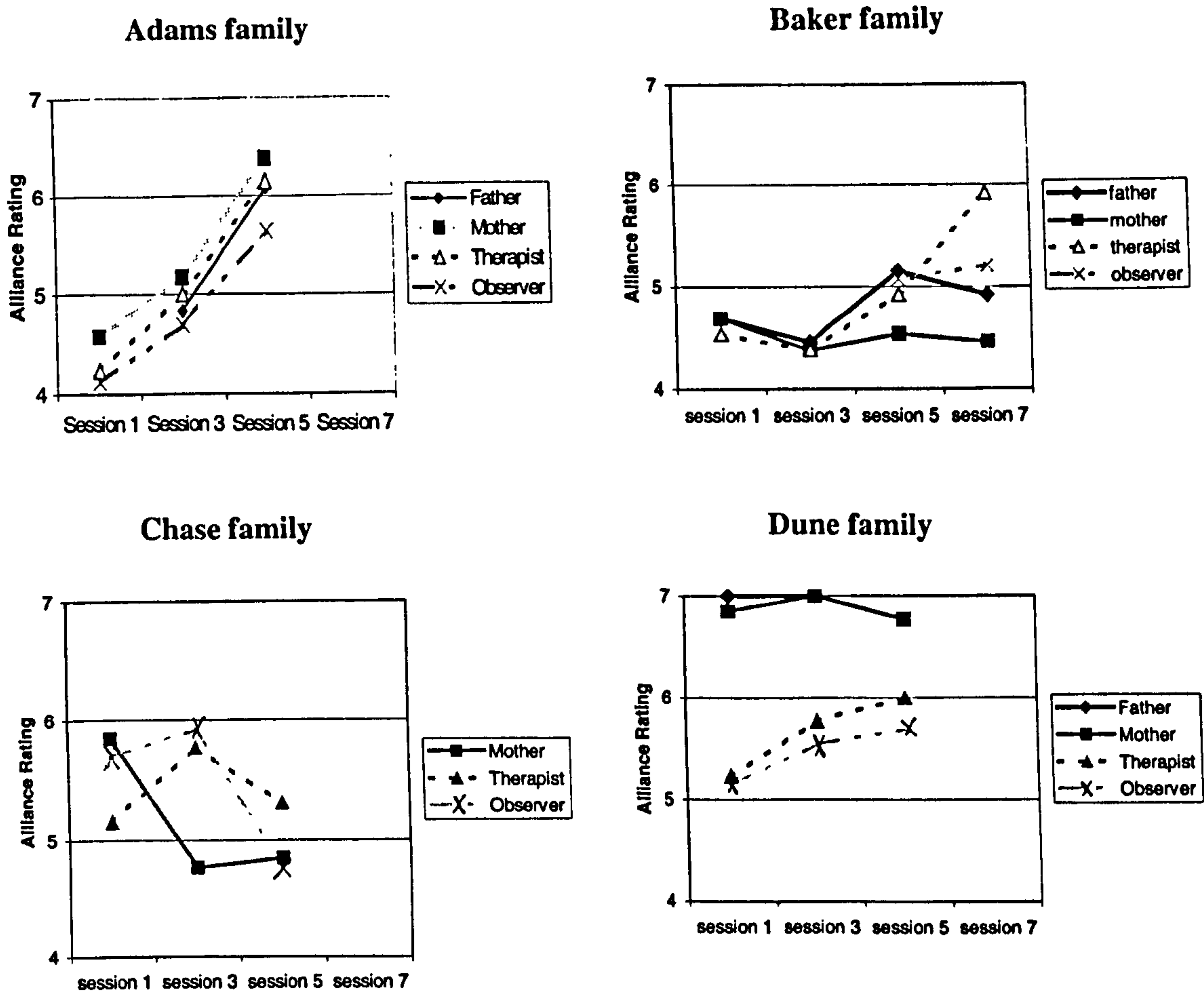
## **Section Five: Family Therapy Alliance Scales**

The therapeutic alliance of the alternative (to the interviews) therapy sessions indicated differences between the families. Figure 2 below illustrates the views of the parents separately, the therapist and the observer therapists<sup>5</sup>. No referred child was old enough to complete the scale.

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<sup>5</sup> Although the scale contains seven points (likert scale), only four up to seven are illustrated in the charts, to enable the reader to more easily differentiate the scores between the various participants.

**Figure 2. Graphs of Family Therapy Alliance Scale scores**



*Note.* A seven point likert scale was used, with a score of 1 indicating a very strong negative alliance, 4 a neutral alliance and 7 a very strong positive alliance, with the points in between allowing more subtle distinctions.

## **DISCUSSION**

### **Overview**

The foregoing analysis illustrates the similarities and differences in participants' experiences of family therapy and the therapist intervention factors that seemed to influence the therapeutic alliance. The analysis described ten master themes that emerged from the interviews. Most prominent from the family interviews were 'child therapy stance and technique', 'children's communication style', 'individual to systemic meaning', 'working alongside', 'being heard', 'not heard' and 'benefit'. Most prominent from the child interviews were 'child therapy stance and technique', 'children's communication style', 'individual to systemic meaning', 'being heard' and 'safety'. The structured therapist commentary produced similar prominent themes to the family interviews, with the exception of 'children's communication style' (present in only one family's themes) and the addition of 'organisation of session'. The theme conceptualised as 'limits of the IPR procedure', was unique to one of the family therapy cases and will be discussed as a methodological issue. This section will discuss further the clinical, methodological and theoretical implications of the master themes.

### **Discussion of Results**

#### *Working with Children*

Efforts the therapist made to form an alliance with the child(ren) were important for the families. This entailed communicating at the level of understanding the child was functioning at, based on their chronological age and perceived cognitive and emotional maturity. Participation could be particularly crucial for a group of children



who often experience significant problems. In the Adams family, for example, the therapist's efforts to communicate with the child were expressed on two levels. The first was the simple and direct way the therapist communicated with the child, and the second, the pace, to enable him to keep up with the therapeutic process. According to Lerner (1996), communicating on the child's level conveys understanding, aiding the development of the therapist's alliance with the child. This study lent support to this. Additionally, this could have had a positive effect on the alliance with the parents. Positive outcome for the child in the Chase family motivated the mother in her participation in therapy (Table 27, p59).

The usefulness of engaging children in family therapy with the aid of child friendly techniques, common to individual child therapy (Dare and Lindsey, 1979), appeared to be relevant to the children and their families. Techniques used included drawings to express their emotional status and an interactive play technique of a concrete situation (football game), where the referred child and her sibling were able to express their feelings and resolve their conflict, coming to their own solutions.

Cederborg (1997) perhaps best explained the nature and quality of the child's participation in family therapy. She conducted a large study of family therapy in order to try to understand the participant status of children and found that children were often side-participants or non-persons. Children are talked about rather than talked to in their presence, resulting in the therapist and adult family members being the subjects acting in respect to the child. Cederborg argued that therapists should think more to ways in which children can more appropriately be included. Giving children the opportunity to communicate at their natural level and valuing their contribution would be making them an active part of the therapeutic language or

discourse and not a side activity. This could have implications for family therapy training.

### *Individual to Systemic Meaning*

The meanings the families ascribed to their difficulties initially seemed quite focussed on the referred child. According to the results, the child could have reacted to the pressure of being blamed by becoming defensive and 'difficult' to parent or communicate with. The parent(s) in all families felt ineffective in their role, which possibly led to a sense of helplessness on their part.

The results gave no indication how the shift occurred, only that it did take place. The shift seemed to occur from a blaming position to one of shared responsibility and empathic appreciation. In subsequent sessions the child in the Adams family felt less blamed and more self-confident, which exhibited itself in greater participation in therapy.

The results seemed to suggest that exploring and understanding each other's views and meanings helped the families to loosen their fixed ideas and allowed a gradual acceptance of shared responsibility. The referred girl in the Chase family explicitly stated relief at not having to shoulder the blame, which led to a greater capacity to come to a solution (with her sibling) (see Appendix 8, p3). However, as illustrated in Table 16, the shift seemed to have occurred to a certain extent but possibly not sufficiently for the referred child. At the second child interview the child still felt misunderstood and unsupported by her mother. This was supported by the results of the alliance scales, where the strength of the alliance took a downward turn in the later sessions.



Discrepant views regarding the parents' understanding of the child's behavioural problems, with the mother continuing to individualise the blame but her partner not, and continuing acrimony between them, contributed to a weak parent alliance in the Baker family. These results concur with Bennun's (1989) findings that therapy was more likely to be unsuccessful with divergent views between parents. The therapy became 'stuck' with no progress being made in the latter stages. Rait (1998) identified ruptures or strains in the alliance as a learning opportunity, for the family and therapist and needed addressing. However, the ruptures remained unresolved and therapy was terminated. The alliance scales supported the weak therapeutic alliance.

### *Multi-Problem Families – Being Heard*

The experience of being listened to emerged as an issue for the family and particularly the referred child. These values could be said to correspond to the core tenets of person-centered therapy (Rogers, 1951), which the families had indicated not to have experienced in their relationship with services. Rogers described empathy as being able to perceive the internal frame of reference of another person accurately, with the emotions and meanings that pertain to it. Within family therapy, Eron and Lund (1993) called the regard for the family as 'joining with a person's preferred view'. Cunningham and Henggeler's (1999) findings that non-specific strategies such as therapist empathy were central to the engagement process, were consistent with this.

In two cases, the Baker and Dune families, the referred child feared being taken into care (for the Dune family, see demographic detail), illustrating the experience and relationship the families had with services. This gave an idea what



possibly lay behind what was often called ‘resistance’ of multi-problem families to treatment. Their feelings of social inferiority and resentment toward the services for not listening to the needs they expressed potentially provided obstacles to developing an adequate therapeutic alliance. This is consistent with findings of Campbell’s (1997) research team that the families in child protection experience significant fear of having their children taken away. Their views were often devalued or ignored by services.

### *The Benefit of Progress and Confidence in the Therapist*

Confidence and hope in the therapist and subsequent motivation for therapy emerged from the perceived progress in therapy in the Dune and Chase families. It encouraged them to further participate and invest in therapy, indicating a positive alliance. In the Dune family progress was experienced as a gradual process and a source of encouragement for the parents, and increased their confidence in parenting their child, as highlighted by them. For the Baker family, lack of confidence in the therapist and therapy seemed to be linked to perceived lack of progress and “stuckness” particularly in the latter stages of therapy, suggesting a negative or insufficiently positive alliance.

In the view of Agnew-Davies, Stiles, Hardy, Barkham and Shapiro (1998), confidence in the therapist was a crucial dimension of the alliance construct for the client, but could also be seen to be impacting positively on willingness to collaborate and affected the on-going alliance positively. In Cunningham and Henggeler’s (1999) study, direct benefit had a positive effect on the family’s alliance to therapy. Progress within the sessions could be a factor that increased self-confidence of family members and confidence in the therapist.

### *Partnership with the Family*

The master theme 'working alongside', prominent in the family interview but absent in the child interview, could be seen to express aspects of the alliance the therapist had with the family as a whole. For the Adams family this meant the active involvement of the referred child in therapy, with the child needing active support by the therapist (see Table 20). Valuing issues brought up by the family could have promoted a sense of partnership. Cunningham and Henggeler (1999) ascribed their success to their collaboration and partnership with families. Agnew-Davies, et al (1998) found partnership to be a distinct factor of the alliance construct, which included the therapist working alongside the family. Collaboration on issues the family brought to therapy seemed central, which could be connected to the family feeling heard (see above in subsection 'Being Heard').

### *Safety*

In the child interview of the Baker and Dune families, the referred child revealed wariness, suspicion and fear of the therapeutic setting and of services in general and feeling vulnerable and insecure in their home environment. The experience of being understood by the therapist seemed to be helpful for the referred child in the Dune family. Their level of distress suggests that what they experience is important to their alliance in therapy. There might need to be an awareness by the therapist to incorporate this in therapy to aid the alliance with children.

### *Organisation of Session*

Although a tentative issue for the families, the Dune family identified the structure the therapist brought to one of the alliance events by focussing on a concrete problematic



event brought by the family, as helpful (see Table 30). The lack of strategic focus by the therapist in the initial stages of therapy was a criticism from the Chase family. These findings concur with the study by Green and Herget (1991), where active structuring was identified in client outcome measures as an ingredient to improvement.

The organisation of the session was more prominent in the structured therapist commentary. The therapist experienced the structure and focus provided in the alliance events to be a factor in how he influenced the alliance.

## **Current Theory**

### *Social Constructionism – a Critical Position*

The gradual re-focussing on the therapeutic relationship within the field of family therapy theories seems particularly relevant to multi-problem families. The results of this study seem to support this.

The results illustrated (most poignantly, in the Baker family) how the family therapist became part of the problem determined system, where the child often fears therapy and the parents feel judged and inferior, which could be linked with resistance in treatment.

Social constructionism was a useful vehicle to examine the approach to working with families in the initial stages of therapy, thus building an alliance and the continued attempts at maintaining it. This encompassed the co-construction of the therapeutic process, which included setting and carrying through the tasks and goals. The setting of tasks within the therapy (for example, the play and drawing tasks) was found particularly helpful for the children and their parents in this study. It encouraged the children's self-expression and participation in family therapy and also



seemed to provide some modeling for the parents. This runs counter to Eron and Lund's (1993) contention, from a social constructionist perspective, that the need for tasks could be bypassed by having a conversation about the meaning of problems, *for the families of the present study*.

Social constructionism could perhaps most helpfully keep its critical position toward psychological theory, research and practice rather than attempting to develop itself into a more concrete theory.

### *Family Therapy and Children*

Very little existing literature or research has been found by the author on the role and participation of children in family therapy, with the focus either on the family as a whole, or the adult members of the family. The exceptions have been discussed earlier. This is particularly relevant in child mental health and multi-problem families, where children's participation in treatment is crucial to their understanding and ethically, is even compulsory (Department of Health, 1999, 2000a, 2000b).

Substantial sources of literature and research on forming therapeutic alliances with children and gaining insight to their developmental and emotional needs are available. These can be found in literature discussing child development theories (Bee, 2000) and the variety of theories and practices of play therapy (McMahon, 1992) and individual child therapy (Lanyado & Horne, 1999).

### **Discussion of Methodology**

Little research has been done eliciting the experience of multi-problem families in family therapy using a qualitative and participative methodology. Valuable information was gained about therapist intervention factors participants found to

influence the therapeutic alliance. The families were thoughtful in their responses, including the children who also participated in the individual interviews. Using as fair as possible reflection of the data in the presentation of results enabled the research to reflect this.

### *Participation*

Recruiting participant families was difficult. This reflected the problems engaging multi-problem families to attend first appointments. With attendance, recruiting the families was relatively problem-free. Every effort was taken to minimise disruption, for instance, the amount of extra time required from the families.

The families participated fully in the interviews, identifying alliance events, either in the form of a specific event, or a whole session (see Table 3, p42). They identified positive as well as mixed (positive and negative) events. This suggested their willingness to be honest and open in reflecting on their experiences, and was reflected in the themes that emerged. The author originally intended the alliance events to be specific parts of sessions. Flexibility was required in accepting the family's views and in certain cases regarding the whole session as the event. The author would, however, need to look at how to make it easier for families to specify events if further research is conducted.

### *The Interview Methods*

The overlapping of thematic material from the family and child interviews, which were conducted following alternate therapy sessions, supports the alliance as a process construct that has continuity through the course of therapy. This has been



evidenced by researchers such as Pinsof and Catherall (1986), Green and Herget (1991) and Luborsky (1994).

The following discussion is based on information from the analysis, observations of the author during the research and the research diary, which was analysed using a form of theme analysis<sup>6</sup> to aid identification of the main issues (Table of themes in Appendix 11).

### The Family Group Interview

Elliott's (1986) method of interviewing, Interpersonal Process Recall, was adapted for use as a group interview method for the family. This was an attempt to get directly to the family's experience and meaning behind helpful therapist factors and to do it in the shortest possible time. The families, as a whole, appeared to have understood the purpose of the interviews and were willing and open in their views. The results of the analysis provided evidence of this.

Due to the multiple participants in family therapy, the therapeutic alliance is a more complex concept than in individual therapy. The alliance can be divided into three levels, the alliance the therapist has with the family as a group, with family sub-systems and with each individual (Pinsof and Catherall, 1986). As the family interviews were group interviews and systemic in nature, the alliance with the family as a collective could be distinguished to a certain degree. The results could be said to reflect the group alliance<sup>7</sup>. Analysing sub-systems alliances had limited success (between the parental and child sub-systems) as no structured attempt was made to

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<sup>6</sup> The theme analysis was loosely based on the first two steps of the grounded analysis by Taylor and Bogdan (1998).

<sup>7</sup> In family therapy, the therapist is seen as joining the family and forming a new system. From the point of view of particularly second-order cybernetics, there is an argument for the existence of a group alliance. Our ability to investigate it quantitatively is limited, however, with the consequent need to rely on qualitative methods.



separate their responses. To look at individual alliances, the third level, either an individual interview needed to be held or the responses of family members analysed separately, neither of which was done.

The alliance event was identified by the parents in two of the families. In the other two this was also done by an older sibling (Adams family) and the referred child and siblings (Chase family). Agreement reached between family members regarding an event seemed genuine, which was corroborated by the participation in and content of the interviews. The referred child contributed minimally to the interview in all but the Chase family. This could have been due to the accompaniment of siblings for the referred child, together with the children's full participation in the alliance event in this instance. It could have also reflected how the therapist developed an alliance with them in therapy, and was possibly not developed enough in the other families. Generally, the referred children seemed to find the interview uncomfortable at times, as it possibly replicated for them the family therapy format.

The suitability of the interview for a parent with learning disability (Baker family) was put into question. The researcher could not guarantee that the parent followed the entire interview and at all times recognised the purpose of the research interview. This point needs to be dealt with in more detail to obtain a satisfactory answer to the question of suitability<sup>8</sup>.

### The Child Interview

The child interview dealt with alliance between the child and the therapist, the third level identified by Pinsof and Catherall (1986).

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<sup>8</sup> Such an investigation could need to include assessing whether the parent is able to identify specific events in the (immediate) past and to what extent be able to reflect on it.

A main issue was the familiarity of the researcher/therapist for the child. An advantage was his insight into the concerns of the child and support he could offer to the child's responses. The danger was influencing or interpreting the child's responses, both of which the researcher had to be vigilant not to do. The independent audit and research supervision probably helped mitigate this danger.

The appropriateness of an individual format was supported in this study. The style of questioning, however, may not have been child-centred enough<sup>9</sup> (Appendix 11), particularly with the youngest, who was five years old. Developing such a child interview would perhaps be worthy of a research project in its own right.

### Structured Therapist Commentary

The structured commentary was kept separate to the interviews in the Results. Reasons for this were to prevent data of the therapist/researcher possibly biasing the other participants' picture of what was helpful. A drawback of these commentaries and why they could not be regarded technically as interviews was the dual role the interviewer had in also being the interviewee.

### *Interpretative Phenomenological Analysis*

The analysis was conducted using the interpretative phenomenological method developed by Smith (1996). The analysis identified factors that come under the form of therapy, such as techniques used. Other factors identified the nature of the therapeutic alliance with children (style of communication) and the family as a whole (for example, collaboration and being heard versus not being heard). The method

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<sup>9</sup> For example, the use of visual communication aids, particularly with younger children, would have made the interviews more effective and would have been easier for the children to respond to.



allowed for an understanding of how the therapist influenced the therapeutic alliance and in a way that allowed for new themes to emerge.

The use of IPA on a transcript of a group interview brings up whether it was possible to have a family view or a collective of individual ideas. This exposed a limitation of the analysis. The results produced a collective or jointly constructed version of the individual family members' views, as they were asked their views and offered them in conversation with each other.

IPA is an interpretative process, with the researcher inevitably being influenced by the lens through which he/she looks. The present author did not pretend to give an objective account but attempted a convincing one of the experiences of the participants.

### *Independent Audit*

The independent audits allowed the validity checking of the analysis the author completed. An intriguing issue to come out of the audit conducted by the research tutor, was that the researcher was too critical in interpreting the participants' data at times. This tendency to be critical rather than positive could be a part of a clinician's mindset, whereas the auditor who was not a clinician, could have been identifying more with the client in her audit. It was also interesting that the auditor who was a clinician picked up far fewer disconfirmations, possibly due to a greater familiarity with the clinical setting and understanding of what the family participants and therapist spoke about.

The audit formed an integral part of the analytical process and gave the opportunity for critical discussion of the interpretations made in the analysis. The data not independently audited were scrutinised again in the light of the new



information. Smith (personal communication) commented on the degree of rigour applied in this analytical process, which he stated was rarely applied. The present author felt the audit increased the credibility of the analysis.

### *Alliance Scale*

The substantially modified scale gave a (flawed) indication of the strength of the alliance in the course of therapy, from the initial to the latter stages. From examination of the figure (p63), the dimension of Task, originally thought to be omitted from the scale, appeared to fit reasonably well the picture that emerged from the qualitative data for each family. For a more rigorous approach to the triangulation process, a validated questionnaire would ideally be used.

### *Sources of Evidence*

This study collated evidence from all participants of the therapeutic process, which converged to provide data that were rich, complex and meaningfully related to the topic. Due to the qualitative nature of this study, the triangulation of evidence by all participants at regular stages of the therapy process was crucial, to combine rigour with comprehensiveness of the data. The quantitative alliance scale, despite its flaws, appeared to reflect the evidence gained from the qualitative analysis.

### *Internal Coherence*

The sampling of decisions made throughout the process of analysis provided the opportunity to evaluate it. The contextual features of the study were also given to ensure the transferability of this study. The provision of clear definitions of concepts,

including core concepts of this study and the themes that emerged from the analysis, also allowed examination.

### *Dual Role of Researcher and Therapist*

The dual role of therapist and researcher (participant and observer) had its implications. Some have been discussed above, such as in the family and child interview sections. The dual role entailed the researcher being more emotionally involved in the study, as he was the therapist and thus wanted the families to succeed in therapy. Structuring the format of the research interviews and keeping mental notes of their purpose hopefully prevented this influencing the interviews to the extent that it would restrict or direct the responses of the families.

The dual role could have also had a positive influence, in that the families were more familiar with the researcher and had established a relationship that allowed more openness. However, it is clear that a degree of positive alliance would have to have been established for this to be the case.

A remaining issue is the influence the research interviews had on the therapy process and the therapist's relationship with the family. As the families were asked about the therapist factors that were of influence, their views were experienced as being valued. This could have increased their confidence and motivation for the therapy. The increased collaboration could have led to a stronger alliance and increased the chances of a better outcome. However, without an effective therapy, the converse could be true. The research interviews could have been a negative (and possibly, irritating for the families) experience. The influence of the research interviews could be seen as reinforcing the therapy progress, but equally, could highlight and perhaps even exacerbate the situation where progress was poor. The

researcher would, as therapist, have taken the knowledge gained from the child and family interviews into subsequent therapy sessions, consciously or not.

### *Ethical Issues*

Confidentiality was crucial, taking into account the small sample, demographic details given and the illustration of their interview responses. Identifiable details were thus omitted.

Often families are reluctant to participate in therapy that has followed a difficult relationship with services. Participation in research should not collude or make use of the potential nature of such a relationship and should ensure sound ethical practice.

Each participant family received a written overview of the results and the opportunity to discuss this with the author (Appendix 12).

### **Implications for Clinical Practice**

This study was born out of a clinical interest to understand more about family therapy with multi-problem families, which would hopefully lead to greater effectiveness as a clinician.

### *The Language of Family Therapy and Children*

Full participation by children in family therapy seems crucial to gain an accurate picture of their experience of problems presented and to come to resolutions thereof. The language of family therapy needs adjusting to include their natural mode of expression, which is often by more indirect means, such as play. Otherwise the therapist would be in danger of marginalising the person in the family that is often



perceived as problematic or experiencing significant difficulties, particularly in multi-problem families. The benefits achieved, among others, by the tasks children carried out, appeared to promote motivation and confidence in the therapeutic process by the participating families. By attending to the goals of therapy and bypassing the tasks, it is probable the therapist could have missed out on a vital dimension for developing an alliance with the referred child and family.

### *Shifts in Meaning*

The significance for clinical practice of the shift from an individual to more systemic understanding of the child's difficulties was illustrated in the relieving of pressure on the referred children.

### *Safety of the Child*

The emotional and physical safety of the referred child as a child protection issue had been addressed before the commencement of family therapy in both cases where this issue was brought up. However, the continuing vulnerability and insecurity the child could experience needs to be taken into account with this client group and is an issue that needs to be dealt with in the therapy or more thoroughly before commencement of any therapeutic intervention, if possible and appropriate.

### *Partnership and Confidence*

The findings of this study may provide some illumination on the contradictory findings from previous research on whether a 'higher' or 'lower' power differential is most efficacious (for example, Hampson and Beaver, 1996; Cunningham and Henggeler, 1999). Confidence in the abilities of the therapist arguably suggests the

utility of what might be seen as an element of higher power differential, while the therapy experienced as an active collaborative process suggests the utility of a lower power differential.

A similar parallelism of higher and lower power could be implied by the findings in the following way: Although the issue of structure did not seem to emerge for the families as prominent, it could be argued that some form of structure, namely, in-therapy behavioural tasks with the children, did emerge. At the same time, however, a non-pejorative or non-judgemental attitude also seemed of particular importance to the families, combined with the experience of their views being heard and understood. It may be that examining these more specific elements of the interaction between a family and family therapist will be more useful than thinking in terms of the interaction in terms of overall power differential.

Perhaps the conclusion to be drawn from these findings is that specific elements of therapist power – such as the utilisation of expertise and skill in therapeutic techniques and in facilitating the family members', particularly the child's, communications – were valued by these families. At the same time, these families had some ideas of their own about what they needed from the services, and it is not very surprising that they should have some ideas and want them to be heard.

### **Implications for Research**

A participant-observer methodology brings particular validity checks along that are crucial for its rigour and the trustworthiness of the material produced by the research. Such research gives accessibility to material otherwise difficult to obtain, particularly with the named client group. Implications of this research could most helpfully be seen within the role such research plays. The primary aim of this study was neither to

theorise nor to confirm an existing theory, but as a starting place from which to explore a topic that has received very little attention from research. This study brought up issues that could usefully be studied in more depth in order to develop theory, particularly a theory that explains the aspects of the therapeutic relationship with multi-problem families. A more comprehensive grounded analysis could be a next step.

### *Interview Method*

The IPR interview method proved useful as a group method but showed its limitations, most notably in level of alliance analysed, when a parent has learning disabilities and in enabling full participation of children. Interviewing children could entail a further research project, as they proved to be valuable sources of information regarding the therapeutic process.

### *Method of Analysis*

The IPA allowed information to emerge that could be beneficial to the clinician, which included aspects of the style of family therapy implemented by the therapist and aspects of the working alliance with children and the family as a whole. It could thus be a useful way of conducting research within a therapy context.

### **Conclusion**

The present study made a start in exploring some of the experiences of multi-problem families in family therapy. The study focussed on those therapist factors experienced as having influenced the therapeutic alliance, either positively or negatively. While the shared meanings of all families were examined, meanings ascribed by the separate



families were retained. The sample size was small and was not regarded as representative. However, the richness of the information generated by this method illustrates its usefulness in family therapy research and revealed useful clinical constructs that can be developed further in research and practice.

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# **APPENDIX 1**

## **Information sheet for families**

## INFORMATION SHEET FOR PARTICIPANT FAMILIES

Date: 1999

Dear Parents,

Family therapy has been offered to you and your child by our service, following your first appointment with us. As has been discussed by us in the first appointment, I am doing a research project into how I as a family therapist can improve aspects of my work in therapy. The research project is the main part of my Doctorate in Clinical Psychology and thus is separate from the [REDACTED] Clinic and the service provided by the clinic. My topic is the following:

**“What factors help in developing a more effective family therapy in child-focussed practice?”**

For this research, I need to:

1. study family therapy sessions I do with clients in order to see what I do, what helps and does not help the therapy process, as well as
2. ask you questions about your opinions on how the therapy is being experienced by you.

I will need your formal consent to do this study. The study will entail me videotaping every session, for me to be able to look at them in detail afterwards. At the end of every alternative session, I would want to ask you to complete short questionnaire on your opinions on how the session went. If your child is too young to complete it, a colleague of mine will ask him in the form of a short interview. On two occasions (over the course of the therapy sessions) you would need to watch a video recording of part of a session which you identified as significant to the session. This will not take longer than ten to fifteen minutes, and takes place after a session. The study should therefore not influence the therapy sessions themselves, nor disrupt them in any way.

Your decision whether or not to take part in this research will not affect you receiving the clinic's therapeutic service. If you have any further questions, you can contact me on [REDACTED]. You can withdraw from the research at any time during the sessions, and this



will not either affect you receiving the clinic's services in any way. Thus, your participation is entirely voluntary and up to you.

I will need you to sign a consent form, which can be done when you come for your next appointment. The video recordings will only be used for my research purposes, and will be destroyed a year after I have completed my Doctorate. I will not use your names at all and the location of the research will be withheld to protect your identity in my research report. The research will only take as long as the family therapy sessions last, thus it could last four session, or more or less. The decision will be based on the number of family therapy sessions you and your child require. After I have completed the research, you will receive a brief report of the findings in writing if you would like this.

If you have any further questions, you can contact me on [REDACTED].

Thank you for your consideration.

Yours sincerely,

**Marc van Roosmalen**  
**Clinical Psychologist/Researcher**

## **APPENDIX 2**

### **Interpersonal Process Recall interviews – Family and Therapist forms**

## **Interpersonal Process Recall (Family Form)**

A. Identification of a vignette by the family members that they found pertinent to the therapeutic relationship.

B. Semi-structured interview

1. How did you find it?

a. then

b. now

2. What was it like?

3. What did the therapist do that was useful (or not)?

4. How did it help, and why?

5. Did it make a difference how you are with your father/son/daughter/mother?

6. How has it affected your relationship with the therapist?

7. How has it affected you coming to family therapy?



## **Interpersonal Process Recall (Therapist Form)**

A. Identification of a vignette by the family members that they found pertinent to the relationship with the therapist.

B. Semi-structured interview

1. How did you find it?

a. then

b. now

2. What was it like?

3. What was it that you did or said that was useful (or not), how did the conversation go that was useful?

4. How did it help, and why

5. Did it make a difference in their relationship with you as their therapist?

5

6. How has it affected the therapeutic process?

## **APPENDIX 3**

### **Child Treatment Alliance Interview**

## **CHILD THERAPEUTIC ALLIANCE INTERVIEW (CTAI)**

1. What is worrying for you at the moment?
2. Do you think that the therapist understands that?
3. How do you know?
4. What did he do or say that was helpful / not helpful? (give an example)
5. Do you think the therapy helps / coming here?
6. In what ways? (give examples)
7. In some ways, has it been unhelpful?
8. How do you think the therapist sees what is wrong?
9. What does Mother think is wrong / worrying?
10. What does Father think is wrong / worrying?
11. Any others?
12. Do you agree with the above, or disagree?
13. Do you think we can help?
14. How do you think we can do this?
15. Any other worries?



## **APPENDIX 4**

### **Family Therapy Alliance Scales – Family, Therapist and Observer versions**

Family Therapy Alliance Scale (FTAS)

Name ..... Date .....

	Comp. Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comp. Disagree
1.The therapist and I are in agreement about the goals of therapy	7	6	5	4	3	2	1
2.The therapist does not understand my child and family	7	6	5	4	3	2	1
3.The therapist has the skills and ability to help me	7	6	5	4	3	2	1
4.I am not satisfied with the therapy	7	6	5	4	3	2	1
5.The therapist and I are in agreement about the way the therapy is going	7	6	5	4	3	2	1
6.The therapist does not understand me	7	6	5	4	3	2	1
7.The therapist understands my goals in therapy	7	6	5	4	3	2	1
8.The therapist is not helping my child and family	7	6	5	4	3	2	1
9.I think I can help my child	7	6	5	4	3	2	1
10.I am in agreement with my partner with regards our child	7	6	5	4	3	2	1
11.The therapist understands the difficulties my child and family are having	7	6	5	4	3	2	1
12.I think my family, the therapist, and I can work together in this therapy	7	6	5	4	3	2	1
13.The therapist is in agreement with my family's goals for this therapy	7	6	5	4	3	2	1

Questionnaire - FTAS-T

Name ..... Date .....

	Comp.	Strongly				Strongly	Comp.
	Agree	Agree	Agree	Neutral	Disagree	Disagree	Disagree
1.The family and I are in agreement about the goals of therapy	7	6	5	4	3	2	1
2.I do not understand the child and family	7	6	5	4	3	2	1
3.I have the skills and ability to help the family	7	6	5	4	3	2	1
4.I am not satisfied with the therapy	7	6	5	4	3	2	1
5.The family and I are in agreement about the way the therapy is going	7	6	5	4	3	2	1
6.The family does not understand me	7	6	5	4	3	2	1
7.The family understands my goals in therapy	7	6	5	4	3	2	1
8.I am not helping the child and family	7	6	5	4	3	2	1
9.I think I can help the child and family	7	6	5	4	3	2	1
10.The parents are in agreement with regards their child	7	6	5	4	3	2	1
11.I understand the difficulties the child and family are having	7	6	5	4	3	2	1
12.I think the child, the family and I can work together in this therapy	7	6	5	4	3	2	1
13.The family is in agreement with my goals for this therapy	7	6	5	4	3	2	1



Family Therapy Alliance Scale (FTAS-O)  
(Observer Version)

Name ..... Date .....

	Comp. Agree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comp. Disagree
1.The therapist and the family are in agreement about the goals of therapy	7	6	5	4	3	2	1
2.The therapist does not understand the child and family	7	6	5	4	3	2	1
3.The therapist has the skills and ability to help the family	7	6	5	4	3	2	1
4.The family am not satisfied with the therapy	7	6	5	4	3	2	1
5.The therapist and the family are in agreement about the way the therapy is going	7	6	5	4	3	2	1
6.The therapist does not understand the family	7	6	5	4	3	2	1
7.The therapist understands the family's goals in therapy	7	6	5	4	3	2	1
8.The therapist is not helping the child and family	7	6	5	4	3	2	1
9.I think the therapist can help the child	7	6	5	4	3	2	1
10.The parents are in agreement with regards their child	7	6	5	4	3	2	1
11.The therapist understands the difficulties the child and family are having	7	6	5	4	3	2	1
12.I think family and the therapist can work together in this therapy	7	6	5	4	3	2	1
13.The therapist is in agreement with the family's goals for this therapy	7	6	5	4	3	2	1

# **APPENDIX 5**

## **Research Diary of Interpretative Phenomenological Analysis**

## **RESEARCH DIARY – IPA ANALYSIS**

### **28.4.00. IPR (Adams family)**

1. It was really difficult to get (referred child) involved in the IPR. He didn't want to be involved or just found it very difficult. I think it's a combination of the two really.
2. It was difficult then to not go into a therapeutic interview rather than a research interview as particularly the mother seemed to encourage and want a therapeutic discussion rather than a research discussion around the topic so in a way I had to bring them back to the research questions continuously actually. This point shows how difficult it is for the identified child or the referred child to partake in a research interview when they are finding talking about a subject within the session already very difficult and then they are confronted with it again in a research interview.
3. That (referred child) wasn't at all involved in identifying the vignette. He was quiet for that which again showed the quality of his and nature of his participation in the therapy sessions itself which shows in a verbal and explicit way very limited. The vignette was actually identified by mother and the older brother.

### **28.4.00. IPR (Adams family)**

1. The issue of influence and who chooses the vignette which is going to be observed and if for instance (referred child - RC) and the mother identifies it although the rest of the family will just go along with that but actually what I did find is that although RC did not actually help identify the vignettes the older brother did quite genuinely and wholeheartedly agree with his mother on the part of the session that he found useful as well and that they actually concurred. I suppose the difficulty occurs when they actually identify separate or different vignettes, which actually hasn't happened to me up to yet but I wonder what will happen then.
2. This is just a thought after going through the IPR of Chase family because the alliance event was identified by the mother and not just by one person. What I actually did is ask the others if that was a significant event for them as well in which the RC actually said nothing, he said nothing at all and the older brother agreed with his mother. I guess I then took that as the alliance event for the family



as the other family members did agree with mother and thought that this agreement was sincere due to them backing it up with their point of view and why they think it was a significant alliance event.

#### **29.4.00. IPR (Adams family)**

1. Though the issue of the referred child and participation in the IPR that he was clearly quite embarrassed in the presence of his parents and siblings and that in combination we were talking about a difficult subject that he really didn't participate in the first IPR at all and in the second one very minimally following a lot of encouragement and that clearly he found it very difficult and this really brings up the issue of the appropriateness really of taking the child going through this and participating in it at all.
2. The second point is that the absence of father has been highlighted twice in this session and in the IPR. The IPR creates a family within a family and wonder what kind of effect the IPR is having on therapy if it could possibly be reinforcing splits between the family that are present and the absent family members because it brings up the issue of absence twice. The IPR can therefore be quite a powerful tool and I wonder what methodological ethical and clinical repercussions this has as it reinforces the split. I also wondered at the effect that it has on RC's identification with his father and that RC was closing off and whether I am reinforcing this by having him actually within the therapy firstly and the appropriateness of the IPR in the second place.
3. It is quite important to do my analysis where the families results get reflected in total and then alternatively see if different members come up with different themes, for instance do the children come up with different themes to the parents etc and then see if both steps can be done for every family therapy process.
4. The next point is really a process question and I am asking myself do I ask the same summary questions or all of the questions to all of the family members and why if I don't. Do I use standard prompts or open-ended questions. Is there really a basic answer to the question of the IPR so the question in a nutshell and do all families say the same thing in other words can I get a real major theme out of the IPR for each family.

#### **30.4.00. IPR THERAPIST VERSION (Adams family)**

1. RC for the first time as the referred child identifies a vignette which is quite significant or he helps to identify it and makes a genuine

contribution to it which seems quite significant really, the first time that this has happened.

### **3.5.00. CTAQ (Adams family)**

1. The referred child seems to benefit from suggestive or leading questions.
2. Being familiar with the therapeutic process and therefore being the therapist as well as the researcher, it seems that I am in a better position to help the child express himself and that where I can help with leading questions because I know what has happened in the therapy. The question is how much I help the child really and that I don't always make a child say something.
3. In the second CTAQ RC was much more responsive, verbally and in his gestures and body language. He was much more engaged with me that makes me think of the point that in the first CTAQ he often said "I don't know you" or "you don't know me so you can't really understand me". In the second he was much more engaged and responsive and maybe it has taken him time to trust me really and this really brings in the question of when first to bring in the CTAQ therefore not in the beginning and not really so near the beginning of the therapy to let the child get to know me as therapist and researcher.

### **5.5.00. IPR (Adams family)**

1. Done IPA's for the first family and I am looking at the relationship between the emerging and main themes. My main themes might be a bit too general and that can only really suffice as general results whereas the emergent themes gives a more specific idea as to what the therapist factors were and that I should look at the relationship between the emerging, super ordinate and master themes and which ones are actually more useful and for what it's useful for.
2. A second thought I have is that in table 2 of IPR of the first family that the emerging themes almost look like a shopping list of guidelines for therapists in working with children in family therapy
3. Another point is when is the alliance itself the changing mechanism and when it is the vehicle in which change takes place in others when the technique itself is the change mechanism. In the emerging themes in table 2 insight into systemic features of child's behaviour is therefore how to develop alliance with a child is a



change mechanism itself or identified as that by the family. Whereas if you look at the emerging theme of therapists needs specific skills to communicate with child it is the technique itself which is the change mechanism and not the alliance. The alliance is therefore not the cause of change but the technique is whereas in the first one the alliance is the cause of change and that's it for the moment.

#### **5.5.00. CTAQ (Adams family)**

1. The issue of the researcher also being the therapist comes up and I am not sure whether this is a disadvantage or an advantage it could be both but that the therapist helps the child to answer the questions or does he help the child by knowing what happened in the therapy and bringing this up as a topic for conversation which according to the researcher as therapist influence or affected the child, for instance on the top of page 2 of the transcript when we also talked about the child's father being ill if it has affected his relationship with the child and let the child to answer some questions on it.

#### **5.5.00. IPR (Baker family)**

1. This is the first IPR and I notice in here that the father or male partner is actually speaking for his wife or his partner and she has learning difficulties. He is speaking for her by telling the researcher that she is possibly finding it difficult to answer the questions because she could have been upset by the revelations that he had made during the session
2. Mother seems to find it difficult to cope with the IPR interview about the traumatic issue just after the session where they talked about it and I wonder if this is possibly this IPR procedure is just too difficult for her because it doesn't really seem to be too difficult for her learning disabilities per se (taking into consideration her learning disabilities) but rather the emotional effect that it is having on her.

#### **5.5.00. IPR (Baker family)**

1. The family weren't able to specify a part of the session that was in any way very helpful or was a significant event at all and I wonder if this has to do with both an indication of how the therapy is going as well as learning disabilities in the family.
2. Mother again has great difficulty with the IPR interview as we are talking about a very difficult topic for her and again I am thinking of



having the session where you talk about difficult issues and in the IPR again and I think maybe mother's difficulties could be possibly learning disabilities and the difficulty with dealing with complex feelings and situations but I think it also shows there the amount of emotional trauma that she experiences and it even questions the appropriateness of an IPR interview with her.

#### **6.5.00. CTAQ (Baker family)**

1. This is the CTAQ of a 5 year old boy and I just wonder what does the child need as an aid to help him or her express himself and how can I ask questions in a better way really for a child of his age that is developmentally better or more at his developmental level.
2. The child's difficulty in expressing feelings directly and in other words verbally and then the amount of interpretation that a researcher can do in such an interview I think is an issue.
3. Connected to the above point is whether the tentative interpretation or observation of a child's behavioural responses to questions is a way of compensating for a lack of verbal ability of a 5-year old child.
4. Wondering to what extent a child can follow a verbal semi-structured interview with a whole number of questions and whether they should be visual as well to help the child to concentrate and focus possibly with faces with expressions etc.
5. I am sceptical whether RC really understands the reason for the semi-structured interview, I actually think he doesn't understand it at all and that for him it's just an extension of the therapy, even though I had gone through this with him. This really brings up ethical issues.

#### **6.6.00. CTAQ (Baker family)**

1. RC found it very difficult to answer the questions and I am really wondering whether it's appropriate for a child of his age. In combination with the possible developmental delay he has got which includes not being able to cognitively understand the questions and answer them accurately. Also understanding in any way the whole context of the CTAQ - why I am asking what I am and that it isn't part of therapy but that it's part of a research project. I am not really sure whether he can make that distinction so I am really thinking along ethical lines whether it's really appropriate what I am doing with such a young child but again not only because of his age but in combination with his cognitive development and if

he can understand the situation he is in with regards to the research. I also think it has to do with his emotional development and needs and not only cognitive.

#### **6.6.00. CTAQ (Baker family)**

1. How difficult RC finds it to respond verbally in a semi-structured interview and I wonder for a child of his age and his level of emotional and cognitive maturity if just a verbal interview with no visual cues etc can be done in a better way.
2. That to develop such a interview with a child will be a research project just by itself really.
3. It took me quite a while to get RC engaged in the semi-structured interview and I wondered if there is another way of better preparing a child for an interview like this - in the way of explaining what you are doing and making sure that they understand what you are doing.

#### **6.6.00. CTAQ (Baker family)**

1. The questions really need to be much more specific and concrete, they are too general and vague and the child doesn't really understand what I am asking.

#### **12.6.00. IPR (Chase family)**

1. This is a mother with 3 children and the importance really of having ground rules for the IPR interview that there is only one person talking at a time because quite often I cannot make out what the person is saying when I listen to the audio tape.
2. Each member of the family had their own view regarding the alliance event where mother was ambivalent for her reasons and the referred child was also ambivalent about the event and the therapy so far. These were for other reasons which were different to her mother's and that the other children also had their feelings. The alliance event doesn't necessarily need to be only positive or negative but can be experienced differently by the different members of the family and that that itself can provide quite valuable information about therapist practice from the different family member's points of view. This then brings a different slant to the necessity that all family members need to identify the same and one alliance as being helpful and that commentary by all the



different family members can actually be quite elucidating or illuminating which is probably a better work.

#### **12.6.00. IPR – THERAPIST (Chase family)**

1. What I have noticed is that because I am both the researcher and the therapist I find that I ask the main question once and what it doesn't seem to lead to sometimes is further questioning with regards to one question because once I've answered it, I've answered it and there isn't another person to ask any further questions regarding the main questions so it does limit the semi-structured interview in a way really.

#### **14.6.00. CTAQ (Chase family)**

1. I think the questions that I've put in the semi-structured interview either need to be made more specific or concrete or there needs to be some kind of visual aids or indirect aids to help the child especially because I am really thinking so much about how to engage children and using indirect techniques and I don't think I've probably thought about that enough with regards to this semi-structured interview.
2. I bring in my dual role as researcher and therapist and I have an ambivalence about this point and that is the one side of it is that it seems to be helpful for me to be the therapist and the researcher because I can help the child speak about things that are no for instance they said they were worried about for instance in the research in the therapy session and that if they say something which seems a bit ambiguous or hesitant then my knowledge of this session can help them express themselves. The other side of the coin is making sure I don't ask leading questions and that I influence their answer too much in that way.
3. I am as researcher and therapist more familiar to the child and therefore not a stranger and therefore a child would be more open I am quite sure to me as I would have developed depending on how many therapy sessions some a relationship of trust which a researcher wouldn't have who is not the therapist as well.
4. I think that at one stage the child is actually confused and doesn't understand the questions I am asking and that it really strengthens my idea that the questions should be more simple and more concrete and possibly even indirect aids.



#### **14.6.00. CTAQ (Chase family)**

1. I am just wondering whether this child wants to be in this interview as he has already processed and looked at very difficult materials in the session and then following this up with again talking about her worries and the aspects of her life she is finding difficult.
2. The child is very monosyllabic and I for what reason that is that he has difficulty expressing herself because of the material and also because of her temperament, or was it due to the fact that it's all verbal that the interview was all verbal and there is no indirect material or child therapy material or techniques to help her express herself.

#### **26.5.00. IPR – THERAPIST (Dune family)**

1. The family found the whole session a helpful event and that the child actually hadn't walked out of the session the whole during the whole time and that he stayed and listened even when showing signs of distress of what was being discussed.

#### **26.5.00. IPR – THERAPIST (Dune family)**

1. The point is again that this is a time when I find a disadvantage of interviewing myself and that is I have less of a chance or ability to ask further regarding therapist factors and therefore there is only question and only one answer and no further questioning. I wonder if it would be better to have someone else as interviewer for these interviews.

#### **26.5.00. IPR – THERAPIST (Dune family)**

1. Quite a lot of answers are circular and repetitive and I am really wondering whether if I was interviewed by someone else that the answers would be more direct and succinct and possibly more in-depth.

#### **2.6.00. IPR (Dune family)**

1. Neither the parents nor the child identified a particular alliance event that identified the whole session as helpful alliance event.
2. The presence of the child is probably quite important even though he doesn't actively participate and that the child is accepted in the position that he is.

# **APPENDIX 6**

## **Ethical approval**

Dear Mr Van Roosmalen

**An analysis of the engagement process of children with complex needs in family therapy within a social constructionist framework - 99.33.16**

Thank you for sending a copy of a revised information sheet which I have now signed giving final approval for the above named study to proceed.

Yours sincerely

*Ian Smith*

Canon Ian Ainsworth-Smith

Chairman

Local Research Ethics Committee

**Please Note:** All research should be conducted in accordance with the guidelines of the Ethical Committee; the reference number allocated to the project should be used in all correspondence with the Committee and the Committee should be informed:

- (a) when the project is complete.
- (b) what stage the project is at one year from today's date.
- (c) if any alterations are made to the treatment or protocol which might have affected ethical approval being granted.
- (d) all investigators whose projects have been approved by this Committee are required to report at once any adverse experience affecting subjects in the study.



# **APPENDIX 7**

## **Nature of Alliance Events**

Nature of all ten Alliance Events

FAMILY	THERAPY SESSION	IDENTIFIED BY	DESCRIPTION OF EVENT	EVENT EXTRACT
Adams	Session 2	Mother & Older Brother of RC (Event identified as having both positive and negative aspects)	(at 44-48 minutes into 60 minute session) Mother and the RC's older brother found it helpful to understand the RC's temper tantrums more in the light of family circumstances and individual temperaments, how the different members were interacting with and affecting one another	T: is that right, RC, what your brother is saying? RC: yea, sometimes T: ...when your father asks you to do something and you can't do it then, he gets frustrated...and you get as well.. RC: yea.. T: and you take it out on your father..... B: or whoever is there.... T: ...your father said he was feeling more positive... RC: it makes me feel a lot better...yea...he used to shout...he doesn't shout to much anymore....(to his mother) when was the last time I had a mood (seemed proud)?
	Session 4	Mother & RC (Event identified as positive)	(at 17-21 minutes into 60 minute session) Father had noticed improvement in RC's behaviour, in part due to his more positive attitude towards his son. Mother said the family situation was better as everyone had the opportunity to express how father's medical condition had affected him and the family	T: ....have the two of you talked about that? P: not really, no... M: not really....we ain't got time to sit down and talk.... P: there's no privacy in the house.... M: ...if I do want to talk to him, something gets in the way and then you've to so something for RC..... P: we've been together for three years and not once have we been out...
Baker	Session 2	Partner & Mother (Event identified as positive)	(at 13-19 minutes into 60 minute session) Mother's partner and mother found it helpful to talk about a crucial parental issue, as they weren't able to talk about it between themselves. The partner was threatening to leave her due to the chaotic home situation and his powerlessness in attempts to parent the RC. Mother, however, found the topic very difficult	P: well. The SW tells us we need to promise RC things to do things for us.... M: yea, she does.... P: I call that blackmail and I don't agree with that... Mo: you shouldn't have to get him to do things because he'll get something, as a five-year-old.. T: you'd like him just to obey M: yea..everyone is telling us different things..
	Session 4	Partner & Mother (Whole session identified as having both positive and negative aspects)	RC's parents felt that FT had not been helpful in changing the RC's behaviour, due to lack of advice given regarding it. Partner felt exasperated due to the lack of improvement in the parental relationship, family circumstances and professional services received. Apparent were mother's low self-esteem, emotional problems and fears of the RC being taken into care.	



	Session 6	Partner & Mother (Whole session identified as having both positive and negative aspects)	The session started with mother talking about support she was starting to receive from Adult Learning Disability service (referral made by therapist) – social and therapeutic support – expressed satisfaction. Although both parents had seen slow progress in their situation, partner expressed frustration at lack of changes in parental or family circumstances. The RC attended the session and expressed a wish to live with mother and partner and without the grandparent, which surprised the parents.	T: what would it be like, being a family? M: he (RC) won't do what he's told P: it's best for me to split, call it a day, I don't like her (M) attitude.. M: I'm scared of being left with it all... T: that's been the reason for the Adult Learning Disabilities becoming involved...to help you cope... P: I'm just lost at the moment,...so many problems. SW said she's never met a family with so many problems.
Chase	Session 2	RC (Event positive) & Mother (Event positive and negative)	(at 10-15 minutes into 60 minute session) A part of the session where the RC described her difficulties at school, which had been frustrating her mother for a few months, she said. The therapist intervened by asking the RC her experiences. Mother struggled to understand her daughter difficulties.	M: you're not going to get your work done, are you (to RC)....? T: what would you say to your mother (to RC). RC:I'm trying... not listen to them... T: are you aware you are doing it? RC: sometimes...and sometimes not... M: she is aware of it...what's she going to benefit..... T: you both say what you're not happy with, now how do you think you can help? B: by not saying nasty things to her RC: and not.... (children argue) T: remember I'm the referee.. RC: to know he's busy sticking up for me..
	Session 4	RC, Twin Sibling (male) & Mother (Event identified as positive)	(at 39-49 minutes of 60 minute session) By enacting a concrete conflict situation between them by a "football game", the RC and twin sibling were able to work through it and come to an agreement, with the help of the therapist as a "referee".	T: you both say what you're not happy with, now how do you think you can help? B: by not saying nasty things to her RC: and not.... (children argue) T: remember I'm the referee.. RC: to know he's busy sticking up for me..
Dune	Session 2	Mother & Stepfather (Whole session identified as positive)	Mother and stepfather found the session helpful and that they were working towards a greater understanding of the RC and his difficulties. They realised the gradual nature of this process and that the RC needed time to open up and express himself.	M: ...the phone call from his (biological) father four weeks ago....his behaviour.... T: do you think he is finding it difficult to hear this, putting his hands over his ears? M & SF: yea... T: how could help him now? M: give him lots of cuddles. SF: give him his space...don't get onto him if he has a tantrum.



Session 4	Mother & Stepfather (Event identified as positive)	(at 24-29 minutes of 60 minute session) Mother and stepfather were surprised at the RC's fear of being kidnapped by his biological father and the pervasiveness of his feeling of lack of safety. The therapist aided his self-expression by using visual scales and coloured pencils, not talking at all.	<p>T: do you feel safe here (to RC)?</p> <p>RC: (shakes his head, while drawing)</p> <p>T: you're still scared...</p> <p>RC: (nods his head)</p> <p>T: it seems as if his fear ...could be a lot of the time...is that right, RC?</p> <p>RC: (nods his head, carries on drawing a pokemon with a big red head that seemed about to explode)</p> <p>M: when I'm at home with RC, he constantly asks when (partner) is going to come back...</p> <p>T: it seems as if the whole family has gone through a difficult time...</p> <p>M &amp; SF: yea..</p> <p>T: what did you find difficult (to sister of RC)?</p> <p>M: when your father didn't want to see you and only your sister, didn't you?</p> <p>S: yea</p> <p>M: she used to cry because she didn't get her dad's attention.</p>
Session 6	Mother & Stepfather (Event identified as positive)	(at 11-20 minutes of 60 minute session) The family talked about an incident where partner stormed out of the house after a family argument, but that they were able afterward to resolve the conflict. This reminded the children about their familys' of origin and difficult issues attached to these.	

*Note.* Abbreviations: M=Mother; F=Father; SF=Stepfather; P=Male partner; RC=Referred Child; S=Sister of RC; B=Brother of RC; T=Therapist

## **APPENDIX 8**

### **Interpretative Phenomenological Analysis: illustration by transcript and table (Chase family)**

#### **Abbreviations:**

**RC = Referred Child**

**R = Researcher**

**M = Mother**

**B = Brother**

**B(other) = Other Brother**

## IPR-Chase family -21.3.00

You've (the family) identified the parts where B and RC you are sitting on both sides of the drawing you made of the football pitch and you were talking to each other about how difficult you both find it in the classroom. Your mother and both of you two said that you found it quite helpful [the interactive game play between RC and Brother – football game].

R: How did you find it sitting in the opposite sides and B, how did you find it

B: I thought it was good

M: : B ... knows what RC thinks now.... understanding each other's feelings

R: OK. And what they like and what they don't like.

M: Yes and being I mean having to compromise and

R: Yes. OK. B and RC how did you find it.

RC: I found it really helpful did you B.

B: I found it excellent (*papers rustling*)

I think that it was a very good to talk.... to each on one side and if I wanted to say something I could...

R: Yes

B: RC, instead of arguing towards each other and RC even gave me something [she said she appreciated that he stuck up for her]

R: OK so you came closer to each other when you talking

B: Because in a football game....walk around each other to each other's goal but if I was like the more opportunity that I had the more I would have wanted to walk this way....I would have walked away from RC

RC: Yeah

R: And what this helped is the two of you coming closer together instead of further apart

B: Yeah

R: Is that right. (to RC)

RC: Yeah

B: So if you was here

R: Yes

B: And I was coming up towards the past the half-way line and he said like she's defending herself in a way that she is saying no of course and the more speed you are doing the more I am going to come back as I move forward

-Play facilitates:  
• understanding  
• exchange of  
stories

-Game play aids  
opportunity to talk

-Expression  
of  
difficult feelings

-develop  
 coping strategies

-processing of  
behavioral options  
in concrete situation

-communicate  
understanding

-turn-taking  
space to talk?

-communicate better

-better comm. vs  
withdrawal

-conflict vs compromise



R: So it was a little bit like the football match then. She is defending herself and you saying no you don't...

R: Yes so how did you find it helpful RC

RC: I find it helpful because we all get time to talk it's more easier for us to talk to discuss it things that we can like things that we can sort out

R: OK so you find it easier to talk in that way

RC: Yes.

R: OK.

M: You know what I find extremely helpful is that sometimes among my community or my friends they can't get through to the children. Where you are and what you are, you are helping.... you can see the side (*of the children*) that I don't even see

R: From another perspective then

M: Do you see what I mean. Yes. I am happy to how it has finished.. How it went. Yes.

R: OK. And what did I as the therapist do that was useful.

M: Well just exactly what I just said.

R: : Yes well back to what I just said um sometimes you feel that it helps

M: Yes

R: From the situation it helps all of you

*B and RC are laughing and it is difficult to hear M.*

R: Now B, what did you find that I did that was useful

B: Asking questions actually.

R: Asking questions

B: Asking questions and when I said to you that when we when I was seeing somebody who understands one person the way they feel.

B: OK.

*B whispering into the microphone makes it difficult to understand*

R: So understanding how everyone felt differently

R: And how do you find that do you think that was helpful (*other B*)

-self-value

-another perspective  
valued  
-needs help - is  
positive

-Gave / over  
meaning of self-  
expression gives  
value to child

-skilled with  
children:  
-understanding  
-how they  
communicate  
-satisfaction!  
benefit to child

-direct questioning  
-feel understood

-direct & simple  
questions  
-Questioning  
reflects  
understanding to  
child

- mother listens to him at FT

B(other): That when people come this is what sometimes happens say we've got to rush yeah and I am speaking to mummy, mummy just walks

R: OK so you like speaking here then

B(other): Hmmm..yes

- last listen to child in FT, not outside

R: Yes OK and RC, what did you what did I then do then that was useful

- thought provoking  
- fairness towards family members

RC: Is the ideas you come with.....They're good ones

M: I find that you are very fair. With each of them.

*Lots of shuffling noises and humming*

- Encourage exploration of ideas  
- Curiosity

R: OK. And RC, what did it make a difference in your relationship with B?

- relief - problem resolution - not solely child's responsibility

RC: Um that things will get better soon. I am really glad that we've sorted it out together.

- sharing of responsibility

R: OK. And M, how has it helped in your relationship with your son and daughter with B and RC?

- child needs support  
- children expected to be self-sufficient

M: Well them being open and being able to communicate ....What their feelings are.....Because this is what I have been asking for at home and it is difficult to get them to sort themselves

R: It's difficult for them to sort things out

- Difficult to give children equal attention

M: Because I'm not always I am not on the school grounds or because sometimes even B says I prefer B (other) or .....Or B or B(other). You know it's a constant B (other).....

- hopeful: FT helping child's self-expression  
- overwhelmed & anxious parent

R: OK. So how do you think B today working that way has affected you coming here

- family relationships important.

B: I don't think I would have understood RC.....in relationships with my family and ....

R: And M, how has it affected you coming here today and the session today and specifically that section in the session. How has it affected you coming here to therapy.

- Callist - expression vs correct behaviour lessening.

- benefit

M: It's definitely positive.

- Support of mother: children benefiting

R: OK well thank you very much that's all for today.



EMERGENT THEMES	SUPER ORDINATE THEMES	MASTER THEMES
Play facilitates: - exchange of stories - understanding gameplay aids child to have a voice also develops coping strategies processing of behavioural options in concrete conflict situations control over manner of expression gives value to child's voice expression of difficult feelings	Interactive child play facilitates emotional expression and behavioural coping strategies	Child centred interactive play techniques (visual aids)
skilled with children: - nature of communication - understanding from child's perspective direct and simple questions questions reflect (communicates) emotive understanding to the child encourage exploration of ideas curiosity for each member's views equally mother's satisfaction connected to benefit to child Hopeful – FT helping child's self-expression support of mother when children visibly benefit sharing responsibility of problems overwhelmed and anxious parent parents listen to child in FT, outside not conflict between emotional expression versus correct behaviour/high expectations lessening	Skills in communicating with children: 1. questioning technique 2. nature of language Supportive and curious Therapist Positive outcome motivates / enhances self-esteem (parent and children)	Positive relationship between developmentally appropriate communication skills with children and client motivation (self-mastery)
	Sharing responsibility for difficulties	Systemic approach (individual to systemic)
	Family loyalty versus emotional expression conflict becoming more flexible – lack of confidence	Containment of family conflict and anxieties

Table 2: IPR – FT session 4 (Chase family)



## IPR- Dune family -19.4.00

The vignette that you (family) identified was the one where RC was pretty scared and I think that you (Parents) said that surprised you

SF: Umm umm..yea.

R: Umm how did you find that was of value

SF: He hesitated a lot with it

M: Yeah it was watching him hesitate then answer (to the scale of 1-10 presented)

R: Umm umm

RC's parents are talking at the same time - not clear what is being said

R: So you don't really know. But how did you find that part of the session when I took the scale...(scale of 1-10)

SF: At least he's opened when he's said nothing for weeks and that he was scared all the time...

R: Do you think it's difficult for him to talk

M: Yes

SF: Yes, it's taken long enough to..... it's like with you last week the last session and we were talking about it and he comes on to me the day before we come here and telling me what had been said

R: So do you think it took him 2 weeks of just coming here

SF: Yes it's taking him a bit of time to talk about his situation, taking his time to open up

R: OK. What was it like seeing him open up in that part of the session. What was it like for you.

SF: It was a surprise that....

R: Umm

SF: to see him opening up and.....

Parents speaking at the same time - difficult to understand

M: He doesn't really say a lot does he. He keeps everything much inside himself you know he doesn't say anything...

R: Is that right RC that you prefer to keep things to yourself, difficult to say what you feel

RC is just playing with his paperclip

M: He's very sensitive to being told off.... you try to tell him off about anything and he's always it's always my fault. That's what you usually get from him which I

Intensity of fear

visual aid

unable to verbalize meaning behind behaviour

empathy

opening up to SF

way/cautious

- child's trust in therapist

- visual aid

- shift - blame

to understanding

- mother supportive of child

- therapist facilitating communication

- child's mistrust of adults

- child's mistrust of adults

- child's mistrust of adults

- child's mistrust of adults

- child's mistrust of adults

- child's mistrust of adults

- expectations

- communication

- discomfort

- despair

- Models of communication - low levels in family

- lack of understanding

feel blamed  
- unhappy

- punitive parenting  
- at odds  
- difficult to be fair

- more confident

- engagement  
- visual aid  
- trust

- defensive  
- uncertain how to help son

- too lenient  
- angry at mother

never used to get from him before but now it's always my fault it's never anyone else

R: Do you think he just started to say things

SF: Yeah

M: Yeah as soon as something goes wrong everyone gets the blame there's three of them in the house and they all get the blame but say something to RC and it's "I always get the blame" for him and storm off but you ain't blaming him directly you are asking him and you've got to do exactly the same to the other two as well

R: OK. So do you think that he is saying more now.

SF: Hmm hmm. *nods*

R: Do you generally.....

M: Oh yeah. He now answers back now where he never used to when I ask him about himself

**R: What did I as therapist do with that part of the session that was helpful. What did I do which you found was helpful or what helped**

SF: You got him to admit to the scared part

R: Hmm

SF: Just with the chart but as before we'd ask him and he would just give you a shrug of his shoulders and you're bringing him out of his shell

R: OK. By the scary part of the session for RC

SF: By the scare yeah.

**R: Does that part of the session did that make a difference to how you are as his dad now and how you are as his mum**

SF: It doesn't make no difference to me as.....

R: How's it affected your relationship with him

SF: Umm umm I suppose it will help me understand him a little bit more maybe be a bit more sympathetic than not and obviously that makes a difference in that respect

R: OK. And you (*to mother*)

M: Well me well he's always had the choice with me hasn't he whereas he's called me what he wants (*swearing*), but lately he's calling me like with the card he made at school for me, getting to write it down and saying how he feels in that way..... it's a big step forward for him

R: Do you think so

- resistant  
- lack of support

- authoritarian parenting  
- distances parent

- therapist facilitating communication

- success

- indirect technique

- confidence in therapist's skills

- SF underconfident in relation to son

- despair at lack of support (child)  
- support in self-expression / supportive of child



- Make more confident

- Child's needs

- Progress - relief - child

M: Yes he's admitting to what he's feeling inside and not bottling up so I....

SF: It's what he wants

M: He wants something steady in his life. That's why he's always being told he can't have things...

*Laughter*

R: Yes it's OK. So you are now feeling that he is communicating to what he wants

SF: Yes. He might do it in a roundabout way but he gets there eventually, it might take a little bit of time but he gets there

**R: How has that part of the session affected your relationship with me as a therapist. Has it affected it in any way or how**

- importance of progress  
- individualises problems

- Therapist as model -  
outside FT  
- therapist objective

- use of FT strategies

SF: Er as far as I am concerned every time we come we get further and so you are helping him it's now down to coming here it's to help him more than anything else

R: Yes

SF: And all we can build on what you put forward and we can go and do whatever follows step by step day by day to see if it comes out and maybe being on the outside helps

R: Yes. OK so what you are saying is that what um what I do with him and what we do in the session it helps you

SF: Yes

R: It helps you outside (*the sessions*) and you .....

M: Yes we try and keep him going outside of it (*the sessions*)

**R: So you said that coming today has really affected you coming to family therapy**

M: Yes

SF: Yes

R: And that only helps you to come here for

M: Now that we want RC to go forwards and not go backwards more

*Mother talking but not clear*

SF: Well it's the only we can start to understand him is by opening up a bit more and understanding yourself

R: So today only helps that process with you coming here and the feeling that it is helping you and

- self respecting  
confidence

- developmental  
needs of child

- Confident in  
FT

- Expectation  
of progress

- Therapist -  
expert/objective  
Transfer of  
skills - help  
child

- Therapist  
convincing

- momentum - anxious

- investment in FT  
- meaning behind  
behavior

- need reassurance  
- strong alliance  
between parents  
- support rather  
than blame



Trust in therapist  
-willing to be led

SF: Oh yeah every time we come here it's a bit from the last session to this one something's come up so from this time to the next one maybe something else will come out  
R: Yes. Thank you.

- Strategic FT  
- gave to therapist

EMERGENT THEMES	SUPERORDINATE THEMES	MASTER THEMES
child's trust in therapist	Child therapy techniques	Child therapy techniques
visual aids to expression		
success in FT		
indirect child techniques		
child's developmental needs	Skilled family therapist	Communication – emotional and developmental needs
FT facilitates child's self-expression		
support rather than blame child		
therapist facilitating communication		
Child self-confidence to express himself		
confidence in therapist's skills		
confident in FT		
expectation of progress		
therapist as objective		
therapist convincing		
shift from blame to understanding of child	Focus change from behaviour to meaning behind it	Individual to systemic
supportive of child		
child resistant		
lack of understanding of child	Lack of parental support	Collaboration
low level of communication in family		
Authoritarian parenting depowers parents		
Parent distances children with parenting style		
Parent underconfident in relation to child		
child – despair at lack of parental support		
Parents need reassurance		
child's mistrust of adults		
strong alliance between parents and therapist		
transfer of skills to parents how to help child		
power to therapist	Alliance with parents	Control over therapy process
strategic FT		
	Directive	

**Table 2: IPR – FT session 4 (Dune family) (Original)**

EMERGENT THEMES	SUPERORDINATE THEMES	MASTER THEMES
visual aids to expression – child responding	Child therapy techniques	Child therapy techniques
indirect child techniques		
FT facilitates child's self-expression	Child struggling to communicate feelings  Confidence in Therapist's abilities with children	Child's developmental and emotional needs
child struggling to respond		
child's mistrust of adults – not responding		
child resistant		
therapist facilitating communication		
confidence in therapist's skills		
child's developmental needs		
therapist as objective		
therapist convincing		
strong alliance between parents and therapist		
child self-confidence to express himself	Positive view of FT – progress made (effective)	Benefit
success in FT		
FT helps understand child		
expectation of progress		
positive about FT		
faith in FT – progress has been made	Defensive parenting style	Working alongside the family
expectation of further progress - positive		
low level of communication in family		
lack of understanding		
Authoritarian parenting depowers parents		
Parent distances children with parenting style	Parents working with/following on from example of Th (to help child)	
feel isolated as parent		
confidence in child	Change in focus from behaviour of child to meaning behind behaviour – greater alliance	Individual to systemic meaning
transfer of skills how to help child		
shift from blame to understanding of child		
Parent supportive of child		
Parent support rather than blame		

**Table 2: IPR – FT session 4 (Dune family) (Audited)**



## **APPENDIX 10**

### **Illustrations of extracts from Child Interviews**

## Illustrations of extracts from Child Interviews

### Child Therapy Stance / Technique

#### 1. Adams family (child interview):

##### Super ordinate theme

Difficult to talk to therapist

##### Emergent themes (clustered)

Difficult – verbalise experience

Therapist as stranger

Defensive in verbal expression

Therapist as stranger:

R: *Do you think I understand you when you say things or not?*

RC: *I don't know it depends.*

R: *What does it depend on?*

RC: *I don't know you.*

#### 2. Adams family (child interview):

Therapist supportive by helping child communicate (*super ordinate theme*). An extract illustrating this theme is the following:

R: *Do you think coming here has helped?*

RC: *Yea.*

R: *How has it helped?*

RC: *I think (the therapist) talking about... like....the family. So how I feel about all the rest of the family (by using indirect drawing methods to communicate his feelings). I think that's the most what helped.*

## Child communication style

Chase family (child interview):

### Super ordinate theme

Age appropriate communication

### Emergent themes (clustered)

Difficulty verbalising when anxious

Age appropriate reasoning

Language style of individual child

Language style of individual child:

R: ...what made you think "Oh I think he understands (therapist)"?

RC: Because you...something that when I tell you about the good memories and the bad memories (therapist speaking style of language of particular child – "good and bad memories").



## **APPENDIX 11**

### **Table of themes from Research Diary**

**Table: Themes of Research Diary, from family, child and therapist interviews**

<b>IPR</b>	<b>IPR – T</b>	<b>CTAQ</b>
Discomfort of child to get involved	Child does contribute to identifying of Event	Suggestive and leading questions, based on knowledge (dual role th/r)
Family continuing therapeutic conversation – no distinction from research interview	Dual role int/ee – limited further probing of answers/responses	Dual role th/r – support for child to answer questions
Child – exposure again to difficult issue	Event = whole FT session	Dual role th/r – familiarity and more responsive – trust important with vulnerable child
Event not identified by child	Dual role – int/ee – further elucidating questions difficult	Dual role th/r – advantage – knowledge of child – support responses
Event identified by two other family members	Limit in breadth, depth of questions, and succinctness	Developmentally appropriate interviewing young child – visual aids
Agreement by fm's regarding choice of Event		Interpretation of responses of child – how much?
Child didn't participate – difficult subject and embarrassment/discomfort		Visual aids
IPR reinforcing work of FT – fm's views and opinions		Does child understand research and interview purpose – distinct from FT?
Identify themes from various fm's		Understanding of – questions(cognitive) and research context – distinct from FT
Question fm's equally		Verbal response minimal
Theories behind themes I develop?		Interviewing children – a distinct research project!
Usefulness of master themes in describing therapist factors – emerging more useful/specific		Concrete and specific research questions
Emerging themes – specific guidelines for		More specific and concrete questions

children in FT			
What is change mechanism – alliance itself(with child) and technique(child therapy)			Visual and indirect communication aids
Partner speaking for parent with LD			Dual role th/r – Adv – help child speak when unsure Disadv – not leading questions – influence responses
Difficult to participate – difficult issues in FT session – double exposure			Dual role – familiar – more open and trust in relationship
Non-identifying of Event – nothing helpful and LD(not able to – specific event)			Communication aids
LD – understand interview and research			Double exposure – difficult issue
Rules for IPR – especially for children – talking one at a time!			Adapting interview for each child: Temperament, cognitive deve. Level and emotional state
Event – experienced differently by fm's - is allowed in IPR – allows for complexity of recording and analysis			
Helpful and enriching meaning of fm's – presentation of meanings (although this doesn't come out in present research, does allow for it)			
Event = whole FT session			
No pressure on child to participate – presence can be positive, included but accepted if no wish to communicate, exclusion has other implications			



## **APPENDIX 12**

**Letter to the family:  
findings of the research**

Date: 2000

Dear *(name of the parents)*

**Re: Research Project – “What factors help in developing a more effective family therapy in child-focussed practice?”**

I want to thank for participating in the above research project of mine. As I promised at the start of the project, I would send you a brief report of my findings on completion thereof. I hope this will be of interest to you.

Your participation entailed me interviewing you as a family and your child separately after every alternate family therapy session, as well as you completing a questionnaire separately after every other session. From these I was able to get what you thought I did as family therapist during the sessions that was helpful and what was not helpful. The information that you gave provided valuable information on what children and families think of coming to family therapy and what they find helpful and unhelpful about the family therapist.

Some issues came up regularly in the interviews. One was that you thought it was important that the therapist was able to speak to your child, who was having difficulties. You wanted to have the confidence that the therapist was skilled in working with your child and helping him or her to talk about his or her difficulties. Another issue that came up was the importance of the therapist listening to you as parents and a family and offering an opportunity to talk about what mattered a great deal to you and was worrying you. You indicated that this has not always been your experience with professional services and that this has been frustrating for you at times.

Listening on its own by the family therapist was not enough on its own though. You also found it important to involve your child in the therapy as much as possible and to help him or her talk about his or her difficulties. This included having the skills to help children talk. Another was being able to work together with you as parents. This to give an opportunity to talk about the difficulties you had been experiencing and to try understand what your child (and you) has been going through. An understanding often helped you with how to help your child. It also gave you an understanding of how all the family members behaving and feeling and how you were affecting each other.

Sometimes having an understanding was not enough by itself and you wanted some specific strategies to help you and your child. Some of these specific strategies we went through in the sessions, some you tried between sessions and others you came up with yourselves in or between the sessions.

It was important for you to see the benefit the sessions were having on your child and yourselves, this would motivate you to attend again.

The interviews I had with your child confirmed a lot what came out of the family interviews. Your child often felt uncomfortable and embarrassed in the sessions and found it very difficult to express his or her feelings. This emphasised the need for the therapist to help the child with this in all the sessions.

- The questionnaires you completed were helpful in indicating how well you thought the sessions were going and how well you thought we were working. Sometimes you thought I was not working that well with you, which was shown in the results of the questionnaires. Looking at the results of the interviews above gives me an idea of what I need to do more or less of and what I need to keep in mind in family therapy sessions.

Thank you again for your willingness to participate. If there is anything regarding the research you want to discuss further with me, we can either arrange an appointment or we can have a telephone discussion, my telephone number is

██████████

Please give my regards and thanks to *(referred child)*

Yours sincerely,

**Marc van Roosmalen**  
**Principal Clinical Psychologist**



